Supreme Court, U.S.
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85-431

No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

HUMANA INC. *et al.*,
Petitioners,

v.

MARGARET M. HECKLER, Secretary,
Department of Health and Human Services,
Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

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QUESTION PRESENTED

Whether Congress, in providing for reimbursement to hospitals for their "direct and indirect" costs of furnishing hospital services to Medicare beneficiaries, *see* 42 U.S.C. § 1395x(v)(1)(A), intended that investor-owned hospitals be reimbursed for their actual costs of attracting and maintaining equity capital used in the provision of patient care.

PARTIES TO THE PROCEEDING

In addition to petitioner Humana Inc., the other parties appearing as appellants in the proceeding below were: Humana of Kentucky, Inc., Humana of Alabama, Inc., Humana Medical Corporation, Humana of Tennessee, Inc., Humana of Texas, Inc., Beaumont Hospital, Inc., Humana of Louisiana, Inc., Winnfield Convalescent Home, Inc., Many Clinic & Hospital, Inc., Brentwood Hospital, Inc., Jefferson Hospital, Inc., Humana of South Carolina, Inc., Humana of Virginia., Inc., Humana of West Virginia, Inc., Humana of North Carolina, Inc., Humana of Florida, Inc., Humana of Illinois, Inc., Humana of Mississippi, Inc., Humana of Aurora, Inc., Humana of New Mexico, Inc., Humana of Kansas, Inc., and Humana of Utah, Inc. All of these additional corporations are wholly-owned subsidiaries of petitioner Humana Inc.*

Appellee below and Respondent here is Margaret M. Heckler, in her official capacity as Secretary of the United States Department of Health and Human Services.

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* Humana Inc. is a publicly-traded company with stock traded on the New York Stock Exchange. In addition to the other petitioners, Humana Inc. does business through a number of other wholly-owned subsidiaries.

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Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

Humana Inc. *et al.* petition for a writ of certiorari to review the judgment and opinion of the United States Court of Appeals for the District of Columbia in this case.

OPINION BELOW

The *per curiam* opinion of the United States Court of Appeals for the District of Columbia (App., 1a-22a) is reported as *Humana Inc. v. Heckler,* 758 F.2d 696 (D.C. Cir. 1985). On April 26, 1985, the Court, *sua sponte,* issued an amendment to the decision (App., 23a-24a). The August 19, 1982 memorandum opinion of the district court is unreported and is reproduced in the Appendix. (App., 25a-37a).

JURISDICTION

The judgment of the Court of Appeals was issued on April 2, 1985 *as amended,* April 26, 1985. *See* Appendix K. A timely petition for rehearing was denied on June 18, 1985. *See* Appendix L. This petition for certiorari is being filed within ninety (90) days of that date. This Court's jurisdiction is being invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

1. Title XVIII of the Social Security Act requires the Federal Hospital Insurance Trust Fund to reimburse hospitals for the "reasonable costs" of services provided to Medicare patients. 42 U.S.C. § 1395(b)(1); 42 U.S.C. § 1395g(a). The Act defines "reasonable costs" as follows (42 U.S.C. § 1395x(v)(1)(A):

> The reasonable cost of any services shall be the cost actually incurred * * * and shall be determined in accordance with regulations establishing the method of methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services * * *. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a

> provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

2. In 1966, Congress amended the Medicare Act to specify the method to be used to calculate the rate of return on equity capital to be paid to nursing homes (Public Law No. 89-713, 7, 80 Stat. 1111 (November 2, 1966), *codified at* 42 U.S.C. § 1395x(v)(1)(B):

> Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

3. The Secretary of Health and Human Services has promulgated regulations to govern the return on equity payable under Medicare both to hospitals and nursing homes (42 C.F.R. § 405.429(a)(1)-(2)):

> (1) A reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers. The amount allowable on an annual basis is determined by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program.

(2) For the purposes of this subpart, the term "proprietary providers" is intended to distinguish providers, whether sole proprietorships, partnerships, or corporations, that are organized and operated with the expectation of earning profit for the owners, from other providers that are organized and operated on a nonprofit basis.

* * *

STATEMENT OF THE CASE

Few sectors of the American economy have experienced the degree of government intervention in the marketplace that has been visited upon the acute care hospital industry since 1965 after passage of the Medicare Act. In the past two decades, nevertheless, this Court has not interpreted the substantive reimbursement provisions of the Act as they relate to hospitals. In the absence of guidance from this Court, the Secretary of Health and Human Services has implemented the Medicare Act on the assumption that she is writing on a clean slate, and therefore has unlimited discretion to define the rights of investor-owned companies that operate hospitals providing services to Medicare patients. In implementing the Program, however, the Secretary has acted contrary to both longstanding precedent of this Court and congressional intent underlying the Act by refusing to compensate investor-owned hospitals for the actual costs associated with equity capital invested and used in furnishing medical care to Medicare patients.

During the past 100 years the Supreme Court consistently has enforced the basic principle that private enterprise is entitled to compensation for their capital costs, including both the return on equity that must be paid to shareholders for use of their investment capital and the attendant income tax liability incurred by the corporation in generating that return. The Court initially relied on the constitutional prohibition of a taking of private property for public use without just compensation to protect public utilities subject to state or federal ratemaking programs. Subsequently, the Court concluded that

statutes prescribing compensation levels to investor-owned companies other than public utilities were "coextensive" with the Constitution's "just compensation" standard, thus making it unnecessary to invoke the constitutional provision directly.

The merger of just compensation standards and statutory requirements is best reflected in the Court's decision in *Federal Power Commission v. Natural Gas Co.*, 315 U.S. 575 (1942). There the Court concluded that payment levels to natural gas producers, established by agency regulation pursuant to the statutory program, had to satisfy the constitutional principle of just compensation. 315 U.S. at 586. Thus, natural gas producers were entitled by statute to just compensation, including the costs of attracting and maintaining equity capital, even though their sales of natural gas under that statute were entirely voluntary and therefore the constitutional protection otherwise available to public utilities was not directly available to them.

Humana Inc. is an investor-owned corporation that, with its wholly-owned subsidiaries, furnishes hospital services to individuals eligible for assistance under the Medicare Act. Under the Act, Congress specified that hospitals are entitled to reimbursement for their "direct and indirect costs" actually incurred in furnishing hospital services to eligible beneficiaries. 42 U.S.C. § 1395x(v)(1)(A). In this litigation, Humana seeks to vindicate its right as an investor-owned corporation to compensation for its actual costs of private equity capital which it has employed in furnishing patient care, consistent with congressional intent and with the protections afforded every other investor-owned company in every other industry under similar statutory control.

In the decision below, the United States Court of Appeals for the District of Columbia Circuit ignored historic precedent and rejected Humana's claim that the cost of capital was a cost of patient care. Indeed, the decision in itself is internally inconsistent on the fundamental issue which Humana must ask the Court to address. Citing the provisions of 42 U.S.C. § 1395x(v)(1)(A) which require reimbursement of the "direct and indirect costs" of patient care, the court of appeals

recognized that "Indirect costs include such items as return on equity capital . . . ." [1] Nevertheless, the *Humana* court concluded that a prior decision in its circuit "preclude[d] a finding that return on equity is payable under § 1395x(v)(1)(A) . . . ." [2] As a result of this decision, Humana was not reimbursed for its actual costs of furnishing patient care to Medicare patients, and it was denied the procedural protections established by the Medicare Act to govern disputes regarding reimbursement for "costs."

The reasoning offered by the court of appeals to justify its conclusion cannot withstand scrutiny under precedent of this Court. Further, the court of appeals ignored the legislative history of the Medicare Act that demonstrates Congress' unequivocal intention that the actual capital costs of investor-owned hospitals be treated as "costs" of patient care. Therefore, Humana respectfully petitions the Court for a writ of certiorari to the Court of Appeals for the District of Columbia Circuit to review the decision below.

A. Procedural History.

1. During its fiscal years ending 1973 through 1977, Humana furnished acute care hospital services to patients eligible for benefits under the Medicare Program. Consistent with the Medicare Act and their contracts with the Secretary, Humana's hospitals filed annual cost reports and successive claims for payment at the close of each fiscal year. *See* 42 U.S.C. § 1395h; § 1395oo. Upon receiving these reports the Secretary's "fiscal intermediary," an insurance company such as Blue Cross which contracts with the Secretary to administer the Program, audited Humana's cost reports and rendered an initial determination as to the amount of reimbursement to which it believed Humana was entitled.

2. In the cost reports filed with the intermediaries Humana included claims for reimbursement for three categories of costs

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[1] App., 3a.

[2] App., 14a, *citing American Medical International v. Secretary*, 466 F. Supp. at 613 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. Cir. 1981).

it incurred by reason of its status as a proprietary, investor-owned organization. These "proprietary" costs include:

> (1) *Return On Equity.* To attract and maintain equity capital, Humana must earn a return on the equity capital of the company, which is either distributed to shareholders as a return on their investment or reinvested in the company.
>
> (2) *Income Taxes.* The federal and state income taxes levied on Humana's return on equity reduce the total earnings available to distribute to Humana's shareholders. Because shareholders make investment decisions on the basis of the after-tax earnings of the company—*i.e.*, the total amount available for distribution to shareholders—the after-tax return on equity earned by Humana must be competitive in the capital markets from which it obtains investment capital.
>
> (3) *Stock Maintenance Costs.* Humana directly incurs transactional costs to gain access to equity capital markets, from which it obtains private investment capital. These expenses include accounting and other costs related to Securities and Exchange Commission filings, stock transfer fees, and the costs of shareholder meetings and annual reports.[3]

Upon completing its audit of Humana's cost reports, the fiscal intermediaries denied in whole or in part Humana's claims for reimbursement of each of these costs.[4]

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[3] Humana sought reimbursement for Medicare's share of Humana's stock maintenance costs and federal and state income tax liability. In addition, Humana sought Medicare reimbursement for Humana's actual, after-tax cost of attracting and maintaining equity capital invested in the facility. While the Program reimburses investor-owned hospitals for a return on equity capital at a rate established by a regulatory formula, *see* 42 C.F.R. § 405.429, Humana contends that the rate prescribed by regulation is illegal because it yields an after-tax rate far below Humana's actual cost of capital. *See infra* at 16-17.

[4] Humana's claims for reimbursement of Medicare's share of its stock maintenance costs and federal and state income taxes were denied outright. Humana's claims for reimbursement of its actual costs of equity capital were denied to the extent they exceeded the amount permitted under 42 C.F.R. § 405.429. *See* Appendices D-J.

3. Pursuant to the Act, Humana appealed the intermediary's determination to the Provider Reimbursement Review Board, an adjudicative panel within the Department of Health and Human Services. *See* 42 U.S.C. § 1395oo. Although the Board granted Humana's claims for some of these costs,[5] the Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration, reversed those decisions and denied all of Humana's claims. *See* 42 U.S.C. § 1395oo(f).

4. Exercising its right to judicial review of the agency decision, *see* 42 U.S.C. § 1395oo(f), Humana filed complaints in the United States District Court for the District of Columbia seeking review of each of the decisions of the Board (or the Administrator) denying Humana's claims for the five fiscal years.[6] In an unreported memorandum decision dated August 19, 1982, the district court entered summary judgment against Humana on all of the claims for reimbursement of proprietary costs. App., 25a-37a. On appeal, the United States Court of Appeals for the District of Columbia Circuit affirmed the district court decision. *Humana Inc. v. Heckler*, 758 F.2d 696 (D.C. Cir. 1985); App., 1a-24a.[7]

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[5] *See* 42 U.S.C. § 1395oo(f)(1). The Board upheld Humana's claims for stock maintenance costs for all fiscal years at issue and Humana's claims for income taxes in its fiscal years ending 1976 and 1977 to the extent those taxes are attributable to the return on equity paid to Humana. *See Humana Inc.*, PRRB Dec. No. 81-D12 (Feb. 5, 1981) (App., Appendix D).

[6] The fifth lawsuit, No. 82-1989, involves the separately-filed claims of one of the Humana subsidiaries, Humana of South Carolina, Inc. In that action the individual subsidiary challenged the legality of 42 C.F.R. § 405.429 without first presenting its claims to the Provider Reimbursement Review Board. After it was determined that the district court did not have jurisdiction to hear those claims until after they had been considered by the Board, *see Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978), the case was consolidated with the others then pending in the district court. *See* App., 4a n.7.

[7] Throughout the administrative and judicial process, twelve of Humana's hospitals also had asserted distinct claims for reimbursement of other capital costs denominated by the court below as "stock acquisition costs." The Court of Appeals for the District of Columbia Circuit vacated the district court decision denying Humana's claims in the case of eight of the twelve hospitals asserting stock acquisition cost claims. *See* App., 14a-22a. Humana does not seek review of that portion of the District of Columbia Circuit's decision.

B. Statutory Framework.

1. This case calls for an interpretation of two sections of the Medicare Act. The first provision, 42 U.S.C. § 1395x(v)(1)(A), which was part of the Medicare Act as originally enacted in 1965, requires the Secretary to reimburse hospitals for their "direct and indirect costs" of furnishing hospital services. Humana claims that its capital costs are indirect costs of patient care, and that reimbursement for its capital costs must comply with the requirements of this section.

Endorsement of Humana's interpretation of the statute has two implications. First, Humana would be entitled to reimbursement for its *actual* cost of obtaining equity capital, which the District of Columbia Circuit recognized as an "indirect cost" of patient care. Second, Humana would be entitled to an individualized determination of its actual costs of equity capital and, if the methods adopted by the Secretary in regulations to calculate payments to Humana produced reimbursement that is inadequate, the Secretary would be required to make "suitable retroactive corrective adjustments" for each fiscal year at issue. *See* 42 U.S.C. § 1395x(v)(1)(A)(i).

2. The Court of Appeals, however, sustained the Secretary's contention that proprietary costs are not indirect costs of patient care.[8] This finding directly contradicts the Secretary's own regulations, which during all relevant periods specified that:

> . . . a reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers.[9]

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[8] *See* App., 8a-9a (stock maintenance costs); *id.* 9a-12a (income taxes); *id.* 12a-14a (return on equity capital).

[9] *E.g.*, 20 C.F.R. § 405.429 (1976). The regulations regarding a return on equity capital were amended in 1983 to reflect the implementation by Congress of a new reimbursement program which included changes in reimbursement levels for capital costs of proprietary hospitals. 48 Fed. Reg. 39811 (Sept. 1, 1983), *codified at* 42 C.F.R. § 405.429 (1984).

Similarly, as noted above, this finding is directly contrary to the *Humana* court's stated understanding that "Indirect costs include such items as return on equity capital. . . ." App., 3a.

3. In reaching this conclusion, the Court agreed with the Secretary's contention that Humana's hospitals could claim a return on equity only as prescribed by a different section of the Medicare Act that has absolutely nothing to do with investor-owned hospitals.[10] This provision of the Medicare Act, which is the second section of the Act that must be evaluated in this case, was adopted in 1966 to require the Secretary to guarantee nursing homes a formula-derived rate of return on equity capital. *See* 42 U.S.C. § 1395x(v)(1)(B).[11]

4. Upon concluding that the claims of Humana's hospitals had to be evaluated under the 1966 nursing home amendment, the court of appeals rejected Humana's contention that it was entitled to the protections of § 1395x(v)(1)(A). First, the court reasoned that Humana was not entitled to reimbursement for its actual costs of attracting and maintaining equity capital, but instead was limited to the far lower rate of return on equity capital established under the 1966 nursing home amendment. App., 13a. Second, the court rejected Humana's claim that it was entitled to an individualized determination of its actual amount of proprietary costs it incurred, because the right to that adjudication does not exist for disputes over reimbursement levels for payments under the 1966 nursing home amendment, but instead extends only to disputes over reimbursement levels for "costs." App., 14a.

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[10] *See* App., 14a.

[11] *See infra* at 16-17.

REASONS FOR GRANTING THE WRIT

I. THE DECISION BELOW IGNORES ESTABLISHED PRINCIPLES WHICH HAVE HISTORICALLY RECOGNIZED THE ACTUAL COSTS OF CAPITAL AS A COST OF GOODS AND SERVICES

In producing goods or supplying services, the expenses incurred by an investor-owned corporation associated with its proprietary status and the attraction of private investment capital historically have been recognized as "costs" for which the corporation must be reimbursed. This established principle is best reflected in this Court's decision in *Federal Power Commission v. Natural Gas Co.*, 315 U.S. 575 (1942). There, in defining the statutory term "lowest reasonable rates" under the Natural Gas Act, *see* 15 U.S.C. § 717, this Court concluded that the "Congressional standard coincides with that of the Constitution." 315 U.S. at 586.

Indeed, any other construction would have been nonsensical: Congress knew that it could not induce the voluntary sale of adequate supplies of natural gas by prescribing statutory payments that by definition were confiscatory. Similarly, Congress could not have expected the participation of investor-owned hospitals in Medicare without compensating them for the costs of capital.

The just compensation principles, which have been developed by this Court in nearly a century of ratemaking litigation under a variety of regulatory schemes, clearly established the right to compensation for the costs of capital. For example, this Court has held that "what the company is entitled to ask is a fair return upon the value of that which it employs for the public convenience." *Smyth v. Ames*, 169 U.S. 467, 547 (1898). "Rates which are not sufficient to yield a reasonable return on the value of the property used at the time it is being used to render the services are unjust, unreasonable and confiscatory . . . ." *Bluefield Waterworks & Improvement Co. v. Public Service Commission*, 262 U.S. 679, 690 (1922). The decision of the Court below, by ignoring precedent, is directly contrary to the historical concept of "costs."

The concept of costs under precedent includes compensation for taxes attributable to return on equity, contrary to the decision of the court of appeals. *See* App., 9a-11a. "Normally included as a cost of service is a proper allowance for taxes, including federal income taxes." *FPC v. United Gas Pipeline Co.*, 386 U.S. 237, 243 (1967). Taxes are "properly treated by the company as part of its operating expenses, to be paid out of its earnings before the net amount could be arrived at applicable to dividends, and, if such latter sums were not sufficient to permit the proper return on the property used by the company for the public, then the rate would be inadequate." *Willcox v. Consolidated Gas Co.*, 212 U.S. 19, 51-52 (1908).[12] The income taxes generated by the need of an investor-owned corporation to compensate shareholders for the use of their capital have always been treated as a "cost" of furnishing services under ratemaking programs.

The rejection of this precedent by the Court below on the ground that Medicare participation is voluntary (App., 10a-11a), is without merit. The position of producers under the Natural Gas Act and of hospitals under the Medicare Act is indistinguishable. Unlike public utilities, neither gas producers nor hospitals are required to sell their product or services, the hallmark of a "taking" under the Fifth Amendment. Yet no court has explained why compensation levels for voluntary sales under the Medicare Act need not, under the statute, similarly comply with constitutional standards.[13]

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[12] Contrary to the lower court's decision, the total exclusion of tax liabilities from reimbursement calculations is not warranted because of the disparate tax treatment of different proprietary facilities. *See* App., 10a-11a. Ratemaking agencies have routinely "normalized" a regulated company's year-to-year tax liability "less future consumers be compelled to subsidize present consumers being served by operations accruing tax liabilities." *Chicago v. FPC*, 385 F.2d 629, 633 (D.C. Cir. 1967), *cert. denied*, 390 U.S. 945 (1968).

[13] That Medicare reimbursement is retrospective rather than prospective (App., 11a), does not justify the result below. At most, a retrospective compensation structure might provide greater security of investment, and thereby warrant a lower rate of return than that paid under a prospective rate structure. It does not, however, justify the wholesale exclusion of capital costs from compensation calculations.

II. THE DECISION BELOW IGNORES THE CONGRESSIONAL MANDATE THAT INVESTOR-OWNED HOSPITALS BE REIMBURSED FOR THEIR DIRECT AND INDIRECT COSTS OF PATIENT CARE.

A. Congress Intended That Proprietary Costs Be Reimbursed As "Direct and Indirect" Costs Under Medicare.

Before the inviolate principles underlying the relationship between the government and private enterprise are abandoned in implementing the Medicare Act, the courts must look to the legislative history of that Act to determine if Congress had that intent. "We cannot impute to Congress such a radical departure from established law in the absence of express Congressional command." *Feres v. United States*, 340 U.S. 135, 146 (1950). When the legislative history of the Medicare Act is consulted, it is immediately apparent that Congress explicitly intended to follow universal practice.

The 1965 cost estimates prepared by the Secretary and relied upon by Congress in enacting the "reasonable cost" standard included provisions for the payment of the costs of equity capital of investor-owned hospitals.[14] Moreover, the Senate Finance Committee understood that the reasonable cost standard by necessity had to include reimbursement for capital costs if Medicare was to have any chance of success:

> Without expectation of a "return on capital" there would be little incentive for the development and participation of proprietary institutions necessary to the successful provision of services to beneficiaries of this program. This point appears so obvious to the staff—and to the chief actuary of the Social Security Administration—that had Congress intended to deny

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[14] *Reimbursement Guidelines for Medicare*, Hearings Before the Senate Committee on Finance, 89th Cong. 2d. Sess. at 58, 110, (May 25, 1966) (testimony of Robert G. Meyers, Chief Actuary, Social Security Administration).

> a "cost of capital" factor to proprietary institutions, it would have specifically exproprietary such an expense.[15]

The only reason that the cost of equity capital is even a topic of discussion under Medicare is that a majority of acute care hospitals in this country are government, charitable, or otherwise non-profit facilities, whose capital needs are met by government funding or charitable contributions, and who therefore do not have to compensate investors for the use of capital. Congress understood and accommodated these differences. The Senate Finance Committee observed that:

> Section 1861(v)(1) of Public Law 89-87 [42 U.S.C. § 1395x(v)(1)(A)], which defines 'reasonable cost,' provides for differentiation in reimbursement between proprietary and non-profit institutions. That provision includes the following sentence:
>
> 'The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies and services . . . .'
>
> The key words here are 'various types or classes of institutions.' *Proprietary and non-profit facilities are different types of institutions within the meaning of the statute.*[16]

Senator Russell Long, Chairman of the Senate Finance Committee, was more succinct:

> [I]t was intended that there should be a return on investment to proprietary institutions . . . .
>
> * * *
>
> [I]t is just unbelievable to think that anyone would propose to use proprietary institutions without allowing a return on equity capital . . . .

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[15] *Id.* at 34 (Senate Finance Committee Staff Report).

[16] *Id.* at 29.

> It seems inconceivable to me—to anyone who believes in the free enterprise system—that if you have one fellow competing with someone else, who paid not a nickel for his plant and equipment, had it all given to him by the Government, or had it donated, where the people even made money by donating it we would suggest that they not allow him something on that.[17]

With this background, the Senate Finance Committee reached a very simple conclusion:

> The difference between proprietary and non-profit facilities can be summarized as follows:
>
> (a) tax treatment;
> (b) availability of grants-in-aid and charitable contributions; and
> (c) normal or traditional expectations of reimbursement.
>
> All of these factors persuade the staff that a distinction is called for by the statute.
>
> * * *
>
> . . . . [R]eimbursement to proprietary institutions should be based . . . on a fair return for equity invested in the facility.[18]

In summary, the legislative history of the Medicare Act displays a clear legislative intent that the uniform practice of compensating owners for the use of their capital would be continued.

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[17] *Id.* at 43, 58.
[18] *Id.* at 30.

B. The 1966 Amendment Establishing A Formula For Determining A Return On Equity To Nursing Homes Is Irrelevant To Humana's Claims.

An evaluation of the decision of the court of appeals rests on its invocation of 42 U.S.C. § 1395x(v)(1)(B), which was enacted in 1966 to establish a formula-derived rate of return to be paid to nursing homes.[19] The 1966 nursing home amendment was passed by Congress in reaction to the regulations adopted by the Secretary earlier in 1966 which had denied any reimbursement to investor-owned companies for their cost of capital. *See* 31 Fed. Reg. 7864 (June 1, 1966). These regulations did not comply with congressional intent underlying the 1965 Act: In introducing the 1966 nursing home amendment, Senator Long advised his colleagues that by omitting reimbursement for costs of capital, "They have made a mistake." 112 Cong. Rec. 23644 (Sept. 22, 1966). In this light, the 1966 nursing home amendment must be viewed as mandate to the Secretary to promulgate regulations consistent with original congressional intent.

Both the court of appeals and Secretary, nevertheless, insist that the inadequate return on equity to hospitals is subject to the limitations of the 1966 nursing home amendment. App., 13a-14a. As a result, the court of appeals held that Humana is not entitled to reimbursement for its actual costs of equity capital, but instead is entitled to no more than the amount paid under the formula established for nursing homes under the 1966 amendment. *Id.* 14a. Additionally, the court reasoned that because reimbursement for the cost of capital is a legislative exception to the cost-based standard, Humana cannot invoke the provision of § 1395x(v)(1)(A)(ii) for an individualized determination of its actual costs of equity. App., 14a.

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[19] Pub. L. No. 89-713, § 7, 80 Stat. 1111 (Nov. 1, 1966), *codified at* 42 U.S.C. § 1395x(v)(1)(B).

In reaching the conclusion sought by the Secretary, the court of appeals has misinterpreted the provisions of the 1966 nursing home amendment. The court recognizes that "the plain language of § 1395x(v)(1)(B) must be our guide." App., 23a-24a. The court, nevertheless, concludes that the "plain language" of a statute that on its face refers only to nursing homes is directly applicable to hospitals. *Id.* 13a-14a. In reaching this conclusion, the court of appeals has abandoned this Court's precedent and has ignored the clear intent of Congress, which warrants issuance of a writ of certiorari.

CONCLUSION

For these reasons, petitioners respectfully request that a Writ of Certiorari be issued to review the judgment and opinion of the court of appeals.

Respectfully submitted,

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85-431 (2)

Supreme Court, U.S.
FILED
SEP 14 1985
JOSEPH F. SPANIOL, JR.
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

No.

HUMANA INC. *et al.*,
Petitioners,
v.

MARGARET M. HECKLER, SECRETARY
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondent.

APPENDIX TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

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APPENDIX A

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 82-1986

HUMANA INC., et al., APPELLANTS

v.

MARGARET M. HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 82-1987

HUMANA INC., et al., APPELLANTS

v.

MARGARET M. HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 82-1989

HUMANA OF SOUTH CAROLINA, INC.,
doing business as COLEMAN-AIMAR HOSPITAL,
a corporation, APPELLANT

v.

MARGARET M. HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 82-1994

HUMANA INC., et al., APPELLANTS

v.

MARGARET M. HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 82-1995

HUMANA INC., et al., APPELLANTS

v.

MARGARET M. HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Appeals from the United States District Court
for the District of Columbia
(D.C. Civil Action Nos. 78-00175,
81-01311, 75-00302, 81-00853, 78-00584)

Argued April 22, 1983
Decided April 2, 1985

Lee Calligaro, with whom *Thomas H. Brock* was on the brief, for appellants.

David B. Palmer, Attorney, Department of Health and Human Services, of the Bar of the District of Columbia Court of Appeals, *pro hac vice,* by special leave of Court, with whom *Juan A. Del Real,* General Counsel and *Lynne K. Zusman,* Deputy General Counsel, Department of Health and Human Services, and *Henry R. Goldberg,* Attorney, Department of Health and Human Services, were on the brief for appellee.

Stanley S. Harris, United States Attorney at the time the brief was filed, *Royce C. Lambert, R. Craig Lawrence* and *Nathan Dodell,* Assistant United States Attorneys, entered appearances for appellee.

Before: WALD and SCALIA, *Circuit Judges,* and BAZELON, *Senior Circuit Judge.*

Opinion for the Court Per Curiam.

PER CURIAM: Petitioners Humana, Inc. and sixty-four of its subsidiary acute care proprietary hospitals appeal from a district court decision limiting reimbursement under the Medicare Act, Title XVIII of the Social Security Act.[1] Humana

[1] 42 U.S.C. §§ 1395-1395xx (1982).

argues that reimbursement should be calculated by means of a formula based on all of the costs it actually incurred in providing services to Medicare beneficiaries. The district court, upholding the decision of the Secretary of Health and Human Services (the Secretary), held that certain of these costs were not necessary in the efficient delivery of needed health services and therefore denied reimbursement.

We affirm disallowance of reimbursement for 1) stock maintenance costs, 2) income taxes, and 3) the inclusion of income tax liability in the calculation of equity capital. We also find that the rate of return on equity capital prescribed by the Secretary was reasonable. We vacate the district court's holding disallowing reimbursement for stock acquisition costs when an acquired corporation is liquidated or merged into the acquiring corporation.

I. BACKGROUND

A. The Medicare Statutory Scheme

In 1965, Congress enacted the Medicare Act[2] (the Act), which created an extensive program of health insurance for the aged and disabled. Part A of the Act[3] entitled participating hospitals to reimbursement for the reasonable costs of medical services with such costs being limited to "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services." [4] Under the statutory scheme, reimbursable costs include both direct and indirect costs of patient care.[5] Direct costs are those directly related to patient care such as nursing services and medication. Indirect costs include such items as return on equity capital and depreciation of plant and equipment. The Secretary is charged with developing regulations "establishing the methods or method to be used and the items to be included in determining [reasonable] costs." [6]

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[2] *Id.*

[3] *Id.* §§ 1395c to i-2 (1982).

[4] *Id.* § 1395x(v)(1)(A).

[5] *Id.*

[6] *Id.*

These appeals challenge the Secretary's determinations regarding certain of these indirect costs: 1) reimbursement of stock maintenance costs, 2) reimbursement of income taxes, 3) the treatment of tax liability in calculating equity capital, 4) the allowable rate of return on equity, and 5) stock acquisition costs.

B. Proceedings Below

All of these appeals, with the exception of *Humana of South Carolina v. Mathews*,[7] began as the subject of administrative proceedings before the Provider Reimbursement Review Board (PRRB).[8] While *Humana of South Carolina* was pending, Humana's fiscal intermediaries[9] disallowed the reimbursement of certain costs to the hospitals. The hospitals appealed to the PRRB challenging the fiscal intermediaries' disallowance in three areas: 1) the cost of federal and state

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[7] 419 F.Supp. 253 (D.D.C. 1976), *aff'd in part, rev'd in part*, 590 F.2d 1070 (D.C. Cir. 1978). This case was filed directly in the district court. The suit challenged the Secretary's method of calculating the rate of return on equity capital to be paid to proprietary hospitals. The district court remanded the case to the Secretary to conduct a study of the factors affecting the economics of proprietary hospitals. 419 F. Supp. at 262. On appeal, this court held that the district court did not have jurisdiction to hear challenges to the rate of return for the post-1973 fiscal years. *See* Humana of South Carolina v. Califano, 590 F.2d 1070 (D.C. Cir. 1978). Humana was first required to submit its claims to the primary jurisdiction of the PRRB. On remand, the case was consolidated with two others then pending in the district court.

[8] *See* 42 U.S.C. § 1395oo (1982).

[9] Fiscal intermediaries, like the Blue Cross Association, are assigned to review providers' claims and to make the payments on behalf of the Secretary. *Id.* § 1395h (1982). The provider hospitals file claims for payment annually with the fiscal intermediaries. 42 C.F.R. § 405.454(f) (1983). The fiscal intermediary then determines which costs are allowable under the Act and how much reimbursement the provider is entitled to for the year. *Id.* If a provider wishes to contest the intermediary's determination, a hearing before the PRRB may be requested. 42 U.S.C. § 1395oo (1982). The PRRB's decision constitutes final agency action unless the Secretary, acting through the Administrator or Deputy Administrator of the Health Care Financing Administration (HCFA), modifies or reverses the PRRB's determination. *Id.* This final decision is then subject to judicial review pursuant to 42 U.S.C. § 1395oo(f)(1) (1982).

income taxes, 2) stock maintenance costs, and 3) costs incurred in acquiring new facilities by purchasing one hundred percent of the capital stock of another corporation.

The PRRB held that: 1) Humana was not entitled to reimbursement for income taxes, nor could it exclude income tax liability from the calculation of equity capital; 2) it was entitled to reimbursement for stock maintenance costs; and 3) subsequent to the acquisition of one hundred percent of the capital stock of other hospitals, five of the hospitals in question were entitled to increase their asset valuation while seven were not. The Administrator of the Health Care Financing Administration (HCFA) later reviewed and reversed the portions of the PRRB's decision which ruled in Humana's favor. Humana appealed these adverse decisions of both the PRRB and the HCFA and filed identical claims for the fiscal years ending in 1974 and 1975. In August 1979, Humana amended its complaint[10] to include additional claims in which the PRRB decision represented final agency action.[11] The district court issued its memorandum opinion in August 1982, affirming the Secretary's decision on all issues.

II. ANALYSIS

A. Standard of Review

The Medicare Act itself[12] incorporates the standard of review set out in section 706 of the Administrative Procedure Act.[13] As a reviewing court, we are permitted to set aside the

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[10] Humana, Inc. v. Schweiker, C.A. No. 81-0853 and Humana v. Schweiker, C.A. No. 81-1311 raise identical issues for the fiscal years ending in 1976 and 1977. These claims were disallowed by the Administrator and are included in this appeal.

[11] Appellee alleges that this court lacks subject matter jurisdiction for Humana's pre-1973 claims. Appellee's Brief at 7a. Since appellants limit their appeal to reimbursement for fiscal years ending 1973 through 1977, we do not find it necessary to address the jurisdictional issue. *See* Appellant's Brief at 4.

[12] 42 U.S.C. § 1395oo(f)(1) (1982).

[13] 5 U.S.C. §§ 701-706 (1982).

Secretary's decision only if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." [14] It is undisputed that Congress, in the statute, granted broad discretion to the Secretary to develop the "reasonable cost" concept through regulations.[15] The Secretary's interpretations of the statutes that she administers are entitled to great deference.[16] With this standard of review in mind, we consider each of the claims.

B. Proprietary Costs

Proprietary costs are those expenses incurred solely as a result of a hospital's for-profit status. These include the costs associated with attracting private investment capital. The specific proprietary costs at issue here are stock maintenance costs, income taxes, the inclusion of tax liability in calculating equity capital, and the rate of return on equity capital. Humana seeks an amount of reimbursement for proprietary costs "limited to a level sufficient to recoup its 'costs,'" including the expenses of attracting investment capital.[17] It argues that all other government programs, except Medicare, allow for reimbursement of all of these costs.[18]

The Secretary contends that these proprietary costs are not costs of patient care as allowed under 42 U.S.C. § 1395x(v)(1)(A).[19] The costs are, in addition, not necessary in the efficient delivery of needed health services as required by 42 C.F.R. § 405.451(a) (1983). The Secretary also maintains that Congress has included recognition of proprietary costs in the allowable rate of return on equity capital, which is based on one and a half times the interest on debt obligations issued by the Federal Hospital Insurance Trust Fund (FHITF).[20]

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[14] *Id.* § 706(2)(A).

[15] Richey Manor, Inc. v. Schweiker, 684 F.2d 130, 134 (D.C. Cir. 1982). *See* Springdale Convalescent Center v. Mathews, 545 F.2d 943 (5th Cir. 1977).

[16] Villa View Community Hospital, Inc. v. Heckler, Nos. 83-1310, 83-1456 (D.C. Cir. March 2, 1984) (per curiam).

[17] Appellants' Brief at 30.

[18] *Id.*

[19] Appellee's Brief at 40.

[20] 42 U.S.C. § 1395x(v)(1)(B) (1982).

Therefore, in the Secretary's view, no reimbursement for proprietary costs was intended under 42 U.S.C. § 1395x(v)(1)(A), the "reasonable costs" provision of the Act.

1. *Stock Maintenance Costs*

Stock maintenance costs include Security and Exchange Commission (SEC) filing fees, stock transfer fees, and the costs of shareholder meetings and reports.[21] Humana contends that "these expenses are no different in substance than either incorporation fees or other corporate expenses, which are reimbursed under the Program, or the transaction costs associated with attracting debt financing, which are similarly reimbursed."[22] It cautions that the Secretary's disallowance of reimbursement for these expenses will result in cross-subsidization, the shifting of Medicare costs to non-Medicare patients, which is prohibited under the Act.[23]

The guiding precedent in this circuit is *American Medical International, Inc. v. Secretary of Health, Education and Welfare* (*AMI*).[24] In *AMI*, the provider hospitals challenged the Secretary's denial of reimbursement for various expenses, including stock maintenance costs. The district court drew, and we affirmed, the distinction between reimbursable and nonreimbursable costs based on the purpose they served:

> A crucial distinction must be drawn between costs which are necessary for the maintenance of a corporate structure and those which are necessary for providing medical services. Stock maintenance costs are necessary for a corporation to exist, but medical services can be provided without the corporate form.[25]

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[21] Appellants' Brief at 12.

[22] *Id.*

[23] *Id.*

[24] 677 F.2d 118 (D.C. Cir. 1981) (per curiam). Although this opinion dealt largely with the issue of collateral estoppel, it explicitly affirmed the portion of the district court's opinion dealing with stock maintenance costs. "For reasons amply delineated by the District Court, we agree that the costs in question are not reimbursable because they were not necessarily incurred in the provision of health-care services to Medicare patients, as is required by the Medicare Act." *Id.* at 119 (footnotes omitted).

[25] *AMI*, 466 F.Supp. 605, 612-13 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. Cir. 1981) (per curiam).

Today we reaffirm this distinction. The purpose of the Medicare reimbursement scheme is to refund the cost of providing medical services. These services can be provided in a variety of settings, both proprietary and nonprofit. It is the Secretary's task to ferret out those costs incurred by proprietary hospitals which actually relate to medical care.

The regulations implementing the Act allow reimbursement for both direct and indirect costs.[26] At some point, however, certain indirect costs become too attenuated to be regarded as for the provision of medical services. To make these distinctions, the Secretary employs the primary purpose test,[27] determining the primary purpose of a given activity and its associated cost.

In the case of stock maintenance costs, submitting SEC filings, paying stock transfer fees, and conducting and reporting on shareholder meetings all serve to protect the shareholders and to enhance their investment.[28] While the indirect effect of stock maintenance activities may sometimes benefit medical services, the connection is too indirect. The Act gives no preference to one particular organizational structure. It should not, therefore, subsidize the continuing costs of a provider's choice of corporate structure.

Humana disputes the distinction between stock maintenance costs and incorporation fees and the transaction costs of attracting debt financing.[29] Again, we find the Secretary has rationally exercised her line-drawing authority. The Act is structured to encourage the creation of medical facilities. Incorporation and the securing of adequate debt financing bring such facilities into existence. Reimbursement for these expenses is consistent with the intent of the Act. Once a facility is in existence and medical services are being rendered, however,

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[26] *Id.* at 610; *see supra* note 4.

[27] *Id.* at 615.

[28] *See, e.g.*, duPont v. Wyly, 61 F.R.D. 615, 632 (D. Del. 1973).

[29] *See supra* note 22.

stock maintenance costs inure primarily to the benefit of shareholders, not patients.

We find Humana's contention that disallowance of stock maintenance costs will result in illegal cost-shifting to non-Medicare patients to be without merit. The prohibition against cross-subsidization applies solely to costs relating to patient care. Since we have determined that stock maintenance costs relate to maintenance of the corporate entity as opposed to the reasonable cost of providing medical care, no cost-shifting has occurred. The Secretary's basis of distinguishing between the costs of patient care and other nonreimbursable costs is both logical and rational.[30]

2. Income Taxes

Humana claims to be entitled to reimbursement for the funds expended in satisfying its federal and state income tax liability. It argues that income taxes are a cost of doing business for investor-owned facilities and are always reimbursed by other government programs.[31] In addition, Humana contends that the income tax liability, if not reimbursed, will be passed on to non-Medicare patients, resulting in prohibited cross-subsidization.[32]

The Secretary contends that income taxes do not act to increase the cost of providing medical care, only to decrease proprietary facilities' profits.[33] We affirm the Secretary's determination. Income taxes, like any other claimed expense, must be evaluated under the reasonable cost standard of 42 U.S.C. § 1395x(v)(1)(A) (1982). Reasonable costs include only those expenses incurred in the efficient delivery of needed health services. The very concept of income taxes, a tax on earned profits, refutes Humana's claim for reimbursement.

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[30] *See* Sun Towers, Inc. v. Heckler, 725 F.2d 315 (5th Cir. 1984) (diasallowing reimbursement for stock maintenance costs based on the reasoning set forth in *AMI*).

[31] Appellants' Brief at 14.

[32] *Id.*

[33] Appellee's Brief at 76.

Relying on the *AMI* court's approach of looking at the purpose of a given expense, we conclude that income tax liability is not a necessary cost of rendering medical care.[34]

As discussed earlier, medical services are provided in both proprietary and in nonprofit facilities. Liability for income taxes comes about only when a proprietary hospital earns a profit. The cost is associated with enhancing the shareholders' investment, not with the provision of medical care.[35] Humana claims that to disallow income tax reimbursement is to differentiate unfairly between proprietary and nonprofit hospitals. The statute and its implementing regulations, however, do not require that all hospitals be treated identically, only equitably.[36] Moreover, the allowance of income tax reimbursement could result in extremely disparate treatment among proprietary facilities themselves. The amount of tax owed can depend on a variety of factors, including financial structure, carryover of past losses, or corporate organization. Two hospitals may offer the same medical services and charge the same fees, yet have vastly different tax liabilities.

The fact that certain other governmental programs provide reimbursement for income tax expenses is not an adequate rationale for providing them under Medicare. Humana's argument focuses on public utility case law, an area not analogous to Medicare reimbursement. First, a hospital's

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[34] The court in *AMI* was faced with slightly different facts than those before us today. In that case, state franchise taxes rather than federal and state income taxes were at issue. By using the analysis already affirmed by this court in its treatment of stock maintenance costs, the district court denied reimbursement for the franchise taxes. The basis for the tax, the generation of net income, was held to be the decisive factor.

> A connection between the tax and the rendering of medical services is essential. Whether such a connection exists can only be determined by a consideration of why the tax is imposed.

AMI, 466 F. Supp. 605, 626 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. Cir. 1981) (per curiam).

[35] The Court of Claims, in a recent case involving the reimbursement of California franchise taxes, stated:

> We cannot read the regulation as plaintiffs would have us do to require the Medicare program to protect profits from the effects of taxation.

Sierra Vista Hospital v. United States, 687 F.2d 422, 427 (Ct. Cl. 1982).

[36] 42 C.F.R. § 405.402(b)(5) (1983).

decision to enter into a contract with Medicare is voluntary. Hospitals are in no way compelled to participate in the program. In contrast, public utilities are forced to operate within a tightly regulated scheme if they are to operate at all. Second, public utilities are strictly prohibited from setting rates that recoup past losses.[37] Unlike ratemaking in the utility industry, Medicare reimbursements have until recently—and at all times relevant to this litigation—been entirely retrospective and based on actual costs.

We find Humana's contention that denial of reimbursement for income taxes results in cross-subsidization to be without merit. The subsidization prohibited by regulation[38] refers to the shifting of the costs of providing medical services between Medicare and non-Medicare patients. Since income taxes do not fall into this "reasonable cost" category, no cross-subsidization has occurred. Whether income taxes are a cost of doing business for proprietary hospitals and whether they are a cost of providing medical services are two wholly distinct issues. We refuse to take the quantum leap required by Humana's argument of equating the two.

Humana asserts that if income taxes are not reimbursed as part of "reasonable costs," the same tax liabilities must not be included in the calculation of equity capital.[39] Humana would then be entitled to a return on equity capital for the funds used to pay income taxes. The Secretary responds that only net working capital actually available for patient care may properly be included in the calculation of each provider's equity capital.[40] We affirm.

> Equity capital includes
>
> (1) the provider's investment in plant, property, and equipment related to patient care . . . and

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[37] City of Piqua v. Federal Energy Regulatory Comm'n, 610 F.2d 950, 954 (D.C. Cir. 1979).

[38] 42 U.S.C. § 405.402(a) (1983).

[39] Appellants' Brief at 67.

[40] Appellee's Brief at 55.

> (ii) Net working capital maintained for necessary and proper operation of patient care activities . . . .[41]

Under 42 C.F.R. § 405.429(a) (1983), return on equity capital, based on one and one-half times the interest on debt obligations issued by the Federal Hospital Insurance Trust Fund (FHITF), is alloted for proprietary providers. In order to calculate the net working capital component of equity capital, the provider's current liabilities are subtracted from its current assets. The sole question here is whether income tax liability must also be subtracted from net working capital.

This question was fully addressed in *AMI*. Explaining why the hospitals' argument against inclusion of income tax liability was inapposite[42] the district court stated:

> This approach misses the mark. These regulations do clearly establish that a return on equity capital is only allowed on that portion of equity capital related to patient care. Therefore, liabilities not related to patient care (such as . . . taxes based on net income) must be *subtracted from working capital* to arrive at the net working capital necessary and proper for patient care services. This is accomplished by *including* the . . . tax liability in the return on equity capital computation.[43]

Income taxes must be subtracted from the hospitals' current assets to arrive at the actual net working capital invested in patient care.[44]

C. Rate of Return on Equity Capital

Humana insists that the rate of return on equity capital permitted by the Secretary,[45] based on one and one-half times the interest on debt obligations issued by FHITF, consistently

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[41] 42 C.F.R. § 405.429(b)(1) (1983).

[42] The arguments made against inclusion of income tax liability in *AMI* were parallel to the arguments before us in this case.

[43] *AMI*, 466 F. Supp. 605, 627 (D.D.C. 1979) (emphasis in original), *aff'd*, 677 F.2d 118 (D.C. Cir. 1981).

[44] *See also* Sierra Vista Hospital, Inc. v. United States, 687 F.2d 422, 427 (Ct. Cl. 1982) (holding that income taxes must be subtracted from assets in calculating working capital).

[45] 42 C.F.R. § 405.429(a) (1983).

fails to meet the true cost of attracting capital.[46] It claims that a proprietary hospital's return must be paid under 42 U.S.C. § 1395x(v)(1)(A) (1976), the "reasonable costs" provision, rather than under 42 U.S.C. § 1395x(v)(1)(B) (1976), the subsection dealing with extended care facilities.[47] The reasonable cost provision contains no such fixed formula for a rate of return on equity. Rather, under this provision the amount of each hospital's reimbursement must be evaluated separately. Humana requests an individualized hearing on the rate of return to which it is entitled.[48]

The Secretary responds that a proprietary hospital's rate of return can be claimed only under the extended care facility provision and not under the reasonable cost provision of the Act.[49] Under that section, she argues, HHS lacks statutory authority for individualized rate-making on a hospital-by-hospital basis. We agree with the Secretary's interpretation.

Although the House and Senate conferees who approved the 1966 amendment enacting the extended care facility provision[50] expected the Secretary to "apply similar or comparable principles in determining reasonable costs for reimbursement of proprietary hospitals for services furnished by them,"[51] the plain language of § 1394x(v)(1)(B) does not appear to authorize payment of return on equity to proprietary facilities. On

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[46] Appellants' Brief at 8-9.

[47] This provision, applicable to nursing homes, states:

> Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed *one and one-half times the average of the rates of interest,* for each of the months any part of which is included in such fiscal period, *on obligations issued for purchase by Federal Hospital Insurance Trust Fund.*

(emphasis added.)

[48] Appellants' Brief at 8-9, 12-13.

[49] 42 U.S.C. § 1395x(v)(1)(B) (1982).

[50] Pub. L. No. 89-713, § 7, 80 Stat. 1107, 1111 (1966).

[51] H.R. REP. No. 2317, 89th Cong., 2d Sess. 3 (1966).

this point, we are bound by our prior opinion in *AMI,* which explicitly affirmed the district court's conclusion that the return on equity capital provision in § 1395v(v)(1)(B) "constitutes the *sole* exception to the basic Medicare principle that reimbursement be limited to those costs actually incurred in providing patient care services." [52] Since *AMI* precludes a finding that return on equity is payable under § 1395x(v)(1)(A), and since § 1395x(v)(1)(B) authorizes the Secretary to set a single, universal rate of return, we hold that Humana is not entitled to an individual determination of a "reasonable" return on equity.

D. Stock Acquisition Costs and Liquidation

In separate transactions conducted between May 17, 1969, and June 18, 1971, Humana acquired 100 percent of the corporate stock of twelve health care facilities, eight of which were subsequently merged or dissolved into Humana or a subsidiary. Humana argues that each of the twelve facilities was "purchased as an ongoing operation" within the meaning of 42 C.F.R. § 405.415(g) (1983),[53] which entitles it to reimbursement for capital costs—including depreciation,[54] interest on loans used to finance the acquisitions,[55] and return on equity[56]—based on its purchase price rather than the cost of the assets to the acquired entities. For transactions in which the acquired facilities remained separate corporations, this claim is foreclosed by *AMI,* which upheld the Secretary's denial of such reimbursement "with respect to the purchase . . . of 100

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[52] 466 F. Supp. at 613 (emphasis added), *aff'd,* 677 F.2d at 118.

[53] At all times relevant to this litigation, the portion of the regulation relied on by Humana read:

> (g) *Establishment of cost basis on purchase of facility as an ongoing operation.* In establishing the cost basis for a facility purchased as an ongoing operation after July 1, 1966, the price paid by the purchaser shall be the cost basis where the purchaser can demonstrate that the sale was a bona fide sale and the price did not exceed the fair market value of the facility at the time of the sale.

20 C.F.R. § 405.415(g) (1971).

[54] *See* 42 C.F.R. § 405.415.

[55] *See id.* § 405.419.

[56] *See id.* § 405.429.

percent of the stock of the [acquired] hospitals . . . ." [57] Humana seeks to distinguish *AMI* on the ground that the "district court evaluated the reimbursement claims on the basis of its interpretation of § 405.415(a)-(b), and not under § 405.541(g)." [58] However, *AMI's* analysis of non-liquidating stock transactions in fact turned on the *statutory* requirement that only health care *providers* be reimbursed for their reasonable costs of patient care,[59] and the court's reasoning controls the case before us:

> To participate in the Medicare program and to be eligible for Medicare payments, a provider must file an agreement with the Secretary pursuant to 42 U.S.C. § 1395cc. While the agreement is in effect, the Secretary will reimburse the *provider* for its reasonable costs of providing patient care to beneficiaries eligible under the program. Such costs are reimbursable only to the extent that they are "actually incurred." 42 U.S.C. § 1395x(v)(1)(A). The providers in this case are the [acquired] plaintiff hospitals, not Chanco. Both before and after the stock transfer, plaintiff hospitals, not their owners, were and are the providers of medical services within the meaning of the Medicare Act. Only *their* reasonable costs in rendering medical services to beneficiaries can be reimbursed.
>
> . . . [I]t would only make sense to allow plaintiff hospitals to be reimbursed for the depreciation costs of assets *that the plaintiff hospitals themselves acquired* because the statute only permits reimbursement for costs "actually incurred." 42 U.S.C. § 1395x(v)(1)(A). This must mean "actually incurred" by the *provider* because it is the provider that is being reimbursed. Reimbursement for depreciation from a cost established by the expenditure of Chanco, the stockholder, would be to allow reimbursement for costs not "actually incurred" by plaintiff hospitals, the providers, and would, therefore, be contrary to the Act.

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[57] 466 F. Supp. at 622.

[58] Reply Brief for Appellants at 4i.

[59] *See* 42 U.S.C. §§ 1395f, 1395cc (1982).

> The regulations reflect this by permitting reimbursement only for the acquisition of facilities, 42 C.F.R. § 405.415 . . . .[60]

The Secretary's construction of § 405.415(g) is thus reasonable, and indeed is required by the underlying statute.[61]

Humana next argues that a step-up in basis is appropriate for the eight transactions in which the stock acquisition was part of a two-step transfer of assets to the acquiror, citing *Pacific Coast Medical Enterprises v. Harris (PCME)*.[62] In that case, PCME acquired 100 percent of the stock of Community Hospital of Los Angeles (Community) in an arms-length transaction, liquidating the acquired company approximately nine months later. The Secretary refused to characterize the transaction as a single purchase of an ongoing provider, but treated the stock purchase and liquidation as distinct events. The stock purchase was analyzed using 42 C.F.R. § 405.626(c)(1979),[63] which established that a transfer of corporate stock "would not, in itself, constitute a change of ownership" requiring the filing of a new Medicare provider agreement.[64] Similarly, the Secretary reasoned, a stock trans-

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[60] 466 F. Supp. at 622-23 (emphasis in original).

[61] Humana suggests that § 405.415(g) can include stock transactions if generally accepted accounting principles dictate a step-up in basis on the books of the acquired corporation following the acquisition. But regardless of the appropriate accounting procedures, the acquired company (*i.e.*, the provider) incurs no actual expenses by being acquired. Similarly, the use of the word "purchaser" instead of "provider" in § 405.415(g) does not bolster Humana's case, since under 42 U.S.C. § 1395f (1982), the "purchaser" must be the "provider" in order to be reimbursed. When only stock is purchased, the acquired company remains the "provider" for which reimbursement claims are recognized. *See* West Seattle Gen. Hosp. v. United States, 674 F.2d 899, 901 (Ct. Cl. 1982); Pacific Coast Medical Enter. v. Harris, 633 F.2d 123, 127 n.9, 129 n.21 (9th Cir. 1980); 42 C.F.R. § 489.18(a)(3) (1983).

[62] 633 F.2d 123 (9th Cir. 1980).

[63] Effective May 5, 1980, 42 C.F.R. § 405.626(c) was recodified as amended at 42 C.F.R. § 489.18(a)(3) (1983). *See* 45 Fed. Reg. 22,935 (1980).

[64] 42 C.F.R. § 405.626(c) (1979). The policy that "[a] transfer of ownership of a provider of services . . . render[s] such agreement invalid as between the Secretary and the transferee." 42 C.F.R. § 405.625(a) (1979), *(footnote continued)*

fer does not constitute a change in ownership of assets for purposes of Medicare reimbursement. The Secretary then analyzed the liquidation of Community under 42 C.F.R. § 405.427(c)(2) (1983), which states that when a provider obtains facilities from an organization owned or controlled by the provider, the allowable basis is the cost of the facilities to the owned or controlled entity.[65]

The Ninth Circuit found "[t]he common usage and understanding of this transaction [to be] overwhelmingly contrary to the Secretary's characterization."[66] Common business practice, generally accepted accounting principles, the Internal Revenue Service, the Securities and Exchange Commission, and the California Commissioner of Corporations all recognized that PCME's 100 percent stock purchase and liquidation was in substance an *acquisition of assets,*[67] and was therefore a purchase of an ongoing operation entitling the acquiror to a new cost basis. The same principles govern our decision today.[68] As in *PCME*, the Secretary separately analyzes Humana's stock purchases and subsequent liquidations. And as in *PCME*, "the Secretary's characterization of [a liquidating] transaction as two independent events, instead of a single purchase of an ongoing provider, [is] arbitrary, erroneous and

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(footnote continues)

between the Secretary and the transferee." 42 C.F.R. § 405.625(a) (1979), was changed effective May 5, 1980. *See* 45 Fed. Reg. 22,935 (1980). The regulations now provide that "[w]hen there is a change of ownership . . . , the existing provider agreement will automatically be assigned to the new owner." *See* 42 C.F.R. § 489.18(c) (1983).

[65] The Secretary has promulgated regulations, prospectively effective February 5, 1979, *see* 44 Fed. Reg. 6912-13 (1979), that explicitly deny a step-up in basis or reimbursement for interest in two-step statutory mergers. *See* 42 C.F.R. § 405.415(*l*) (1983); *id.* at § 405.419(d)(1)(ii).

[66] 633 F.2d at 132.

[67] *Id.*

[68] Needless to say, common business, accounting and legal understanding cannot compel an interpretation contrary to the evident intent of Congress, *see* Richey Manor, Inc. v. Schweiker, 684 F.2d 130, 135 (D.C. Cir. 1982). But it is the normal point of departure in assessing that intent where the object of the statute is to give effect to the economic reality of a transaction. That is the situation we confront here, where "the congressional policy that those who participate in Medicare be able to receive reimbursement for reasonable costs," *PCME*, 633 F.2d at 132-33, refers to costs that are in economic reality borne by the provider.

irrational." [69] While permitting reimbursement for asset purchases but not 100 percent stock acquisitions is "reasonable in light of the statute," [70] it is not reasonable to deny reimbursement for integrated transactions that are, in substance, asset acquisitions. The only possible basis we see for distinguishing Humana's transactions from straightforward asset purchases would be absence of a consistent intent to acquire assets. In *PCME*, the acquiror had intended from the outset of the transaction eventually to transfer to itself the assets of the acquired company.[71] If there is no such intent, then the two-step acquisition is not an *integrated* transaction, and the Secretary's bifurcated analysis is reasonable, if not flatly required by statute.

This analysis is consistent with this court's holding in *Richey Manor, Inc. v. Schweiker*,[72] which involved the purchase of 100 percent of the stock of a for-profit Medicare provider and its subsequent conversion into a not-for-profit corporation. The conversion's only effect

> was to shift ownership of the assets from a for-profit corporation to a not-for-profit corporation. . . . [A]lthough the providers' *stock* changed hands, the *assets* remained in the hands of the [acquired] corporate entity . . . . And, although the corporate entities are not identical, the asset ownership continues to rest with a corporation separate and distinct from the purchaser of the stock.[73]

So characterized, the transaction closely resembled the kind of stock acquisitions for which courts had previously denied stepped-up treatment.[74]

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[69] 633 F.2d at 136.

[70] *AMI*, 466 F. Supp. at 624.

[71] *See* 633 F.2d at 127. *See also* American Medicorp, Inc. v. Schweiker, 714 F.2d 68, 70 (9th Cir. 1983) ("AMI's intent was to acquire the assets of Estudillo"); West Seattle General Hospital, Inc. v. United States, 674 F.2d 899, 903 (Ct. Cl. 1982) ("[i]t is undisputed that it was always the intention of GHS to follow the stock purchase with a merger"); *Chateau Gardens, Inc. v. Harris*, 497 F. Supp. 133, 135-36 (E.D. Mich. 1980) ("Plaintiff had the intent throughout of acquiring the assets as a whole and using them to provide health care services").

[72] 684 F.2d 130 (D.C. Cir. 1982).

[73] *Id.* at 134.

[74] *See* Homan & Crimen, Inc. v. Harris, 626 F.2d 1201, 1210-12 (5th Cir. 1980), *cert. denied*, 450 U.S. 975 (1981); *AMI*, 466 F. Supp. at 621-24.

Richey Manor held only that the conversion of the acquired company to non-profit status was not the equivalent of an asset acquisition for purposes of Medicare reimbursement. The panel in dicta, however, criticized *PCME*, and therefore the rationale of our holding today, for failing to take proper account of the "recapture problem" in liquidating transactions, a concern which is also the focus of the Secretary's argument in this case. Depreciation payments to providers are necessarily based on estimates. If the estimated depreciation on an asset exceeds the actual depreciation (due, *e.g.*, to a faulty estimate of an asset's useful life), the provider may recognize gain upon disposition of the depreciated asset, whereupon the Secretary can "recapture" the excess depreciation payments under 42 C.F.R. § 405.415(f) (1983).[75] The *Richey Manor* court was worried that, since this recapture provision does not apply to

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[75] Section 405.415(f) reads in part:

(1) *General.* Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost. The amount of a gain included in the determination of allowable cost shall be limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included shall be limited to the undepreciated basis of the asset permitted under the program. The treatment of the gain or loss depends upon the manner of disposition of the asset as specified in paragraphs (f)(2) through (f)(6) of this section.

(2) *Bona fide sale or scrapping.* (i) Except as specified in paragraph (f)(3) of this section, gains and losses realized from the bona fide sale or scrapping of depreciable assets are included in the determination of allowable cost only if the sale or scrapping occurs while the provider is participating in Medicare. The extent to which such gains and losses are included is calculated by prorating the basis for depreciation of the asset in accordance with the proportion of the assets [*sic*] useful life for which the provider participated in Medicare . . . .

. . . .

(3) *Sale within 1 year after termination.* Gains and losses realized from a bona fide sale of depreciable assets within 1 year immediately following the date on which the provider terminates participation in the Medicare program are also included in the determination of allowable cost, in accordance with the procedure specified in paragraph (f)(2) of this section . . . .

sales of stock (which is not a depreciable asset), allowing a step-up in basis following a 100 percent stock acquisition would "destroy the symmetry of the regulatory scheme by divorcing a step up in basis [for the purchaser] from depreciation recapture [from the seller]." [76]

The scope of this "recapture problem" is not at all clear. The recapture regulations expressly apply only to the "disposal of a depreciable asset [that] results in a gain or loss . . . ." [77] Since a corporation acquired in a simple stock transaction neither sells depreciable assets nor generally recognizes gain upon a subsequent merger or dissolution, treating a two-step transaction as a stock purchase for purposes of the recapture rules would indeed seem to create the "loophole" feared by the Secretary (and the *Richey Manor* panel). However, if integrated two-step transactions are characterized as asset purchases for purposes of both basis computations *and recapture*, they would trigger recapture obligations for the "selling" corporation.[78] The Secretary suggests that collecting these obligations would present administrative problems. If the acquired corporation is deemed to have sold assets and thereby to have incurred recapture liability, then following a liquidation this liability devolves upon the shareholders who received the "sale proceeds" (which in fact was payment for their stock). These shareholders may be difficult to locate, and would also no doubt be distressed at the prospect of paying their old corporation's "recapture obligations," especially if the characterization of the transaction as an asset sale depends upon the *acquiror's* intent to acquire assets rather than *their* intent to sell stock. Even these problems can be avoided, however, if one views two-step transactions as *sui generis* for purposes of the Medicare scheme, sharing attributes of both stock and asset acquisitions. That is, if the transaction is characterized as an asset purchase for purposes of *generating* a recapture obligation, and as a stock purchase for purposes of determining the *incidence* of the liability, then the acquiror is simply liable for the recapture obligation its transaction generated. On this

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[76] 684 F.2d at 135.

[77] 42 C.F.R. § 405.415(f)(1).

[78] *See* Chateau Gardens, Inc. v. Harris, 497 F. Supp. at 136.

mixed analysis, the only stockholder—and hence the only party responsible for depreciation recapture—of the liquidating corporation following a 100 percent stock acquisition, is the acquiror. In the event of a post-acquisition merger, the surviving corporation (*i.e.*, the acquiror) would inherit the recapture liability of the seller under general principles of corporate law. Thus, though we do not here decide the point, we note that the crisis envisioned by the Secretary and the *Richey Manor* panel is not necessarily imminent. Moreover, as far as the present case is concerned, Humana has agreed to assume any recapture liability of the acquired facilities, and the Provider Reimbursement Review Board conditioned its favorable determinations for Humana on the reimbursement issue upon "the Providers' assuming the responsibility to see that the obligations under the Program relating to any gain to the sellers and appropriate recapture of depreciation are met." [79] But even if the existing regulations do not permit collection of recapture, or would make such collection administratively difficult, that seems to us a problem of the Secretary's own creation, which she must remedy. We believe that the requirements of fair reimbursement should determine the character of the recapture regulations, not vice versa.[80]

III. CONCLUSION

On all issues other than that of a stepped-up basis for liquidating transactions we affirm the rulings of the District Court, which upheld the determinations of the Secretary. As to that issue, we hold that a stepped-up basis was required for liquidations intended at the time of acquisition. This, we may

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[79] Hearing Decision No. 77-D89 at 11 (Dec. 1, 1977), J.A. 322 (decision for cost reporting period ending August 31, 1973).

[80] *See PCME*, 633 F.2d at 135 n.39. *Richey Manor* disapproved this position in dicta. *See* 684 F.2d at 135 n.5 ("there [may be] ways of rewriting the regulations so that a two-step transaction need not prevent recapture, but we deal with the regulations as they stand and see no reason to force Medicare to write different regulations which may raise problems of administration we cannot foresee"). However, we deal in the first instance with the *reimbursement* regulations, and we see no reason to allow an unreasonable application of these regulations in order to forestall potential problems on a collateral matter. *See* Chateau Gardens, Inc. v. Harris, 497 F. Supp. at 136.

note, is not precisely the test applied by the Provider Reimbursement Review Board in its decision which the Secretary reversed on other grounds. That decision accorded a stepped-up basis to specified acquisitions which the Board found to have been followed by "subsequent merger or liquidation *within a reasonable time.*" [81] As we hold, however, under the applicable law and regulations the timing of the transaction, while a powerful indicator of intent to liquidate, was not necessarily sufficient either to require or preclude a stepped-up basis, but the totality of circumstances bearing upon intent should have been considered. In any event, since the Secretary reversed the decision of the PRRB on other grounds, we cannot say that its findings, even as to "reasonable time," were those of the agency. Accordingly, we remand this case to the District Court with instructions that it remand to the agency for determination of the requisite intent and for calculation and payment of any additional sums accordingly due.

So ordered.

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[81] Hearing Decision No. 77-D89 at 10, J.A. 321 (emphasis added).

APPENDIX B

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

SEPTEMBER TERM, 1984
Civil Action No. 78-00175

No. 82-1986

HUMANA INC., *et al.*, APPELLANTS
v.
RICHARD SCHWEIKER,
SECRETARY OF HEALTH AND HUMAN SERVICES

And Consolidated Case Nos. 82-1987,
82-1989, 82-1994 and 82-1995

Before: WALD and SCALIA, *Circuit Judges*, and BAZELON, *Senior Circuit Judge*.

ORDER
(Filed April 26, 1985)

It is ORDERED, by the Court, *sua sponte,* that the Per Curiam Opinion filed on April 2, 1985 be, and hereby is, amended as follows:

Page 16, line 4, the phrase following the quotation mark and the cite to footnote 51 which now reads: "the plain language of § 1394x(v)(1)(B) does not appear to authorize payment of return on equity to proprietary facilities." should read as follows:

> "the plain language of § 1395x(v)(1)(B) must be our guide.".

Per Curiam
For The Court

/s/ GEORGE A. FISHER
George A. Fisher
Clerk

APPENDIX C

United States District Court

FOR THE DISTRICT OF COLUMBIA

C.A. Nos. 75-0302, 78-0175, 78-0584, 81-0853, 81-1311

HUMANA INC., *et al.*, PLAINTIFFS,

v.

RICHARD S. SCHWEIKER,
SECRETARY, DEPARTMENT OF HEALTH
AND HUMAN SERVICES, DEFENDANT.

MEMORANDUM AND ORDER

(Filed August 19, 1982)

In 1965 Congress enacted Title XVIII of the Social Security Act, thereby establishing the "Medicare" program which provides funding of medical care for the aged and disabled. P.L. 89-97, 42 U.S.C. § 1395 *et seq.* "Part A" of the Act, 42 U.S.C. §§ 1395c-1395i-2, concerns reimbursement for the costs of hospital services rendered by "providers" of such services to eligible persons. Under the Act the basic feature of this concept of reimbursement is that a provider be reimbursed only for the reasonable cost of its medical services to eligible persons, and such cost is limited to "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(I)(A). This same section of the Act further provides that these reasonable costs are to be determined under regulations developed by the Secretary of HEW "establishing the methods or method to be used and the items to be included in determining such costs." *Id.*

In the above-captioned cases Humana Inc. and 64 of its subsidiary hospital corporations, ("providers") challenge certain regulations and decisions made by the Secretary via delegation to the Administrator of the Health Care Financing

Administration (the Administrator) relative to allowable Medicare reimbursement for fiscal years 1973-1977, and to some extent for a period prior to 1973.

These cases have been consolidated pursuant to the joint motion of the parties and are presently before the court on cross-motions for summary judgment on the various issues raised.

I. BACKGROUND

A. Civil Action No. 75-0302

On March 5, 1975, Humana of South Carolina, Inc., a subsidiary of Humana, Inc., filed suit in the United States District Court for the District of Columbia challenging the method by which the Secretary calculated the rate of return to be paid to proprietary companies on capital invested in the facility at which medical services are provided to Medicare beneficiaries.

The Secretary by regulation limits the rate of return on equity paid under the Medicare program to one and a half times the interest of certain federal debt obligations. 42 C.F.R. § 405.429. The plaintiff claimed that the rate of return was inadequate because (1) it did not fully reimburse for the reasonable cost of attracting investment capital, (2) it resulted in the subsidization of Medicare patients' costs by non-Medicare patients which violates 42 U.S.C. § 1395(x)(v)(1)(A), and (3) the Secretary acted arbitrarily and capriciously in establishing the rate of return provided in the regulation. On June 7, 1976, this court held that 42 U.S.C. § 1395(x)(v)(1)(A)(i), which requires that the Secretary "take into account both direct and indirect costs of providers of services," obligates the Secretary to conduct a study determining the various factors affecting the economics of the proprietary hospital industry. The Secretary was directed to conduct such a study. *See Humana of South Carolina, Inc. v. Mathews,* 419 F. Supp. 253, 262 (D.D.C. 1976).

The Secretary appealed the decision and, on September 18, 1978, the Court of Appeals determined that the district

court lacked jurisdiction to hear Humana's challenges to the rate of return regulations for fiscal years ending after 1973. *Humana of South Carolina v. Califano,* 590 F.2d 1070 (D.C. Cir. 1978). The Court of Appeals held that Humana had to present these issues to the Provider Reimbursement Review Board (PRRB) before it could obtain judicial review. Inasmuch as the plaintiff was seeking reimbursement for both pre-1973 and post-1973 fiscal years, the Court of Appeals held that the lower court ought not consider the pre-1973 claim until after the plaintiff had submitted its post-1973 claims to the PRRB. On remand, the case was consolidated with the two cases described below that were then pending before Judge Gasch.

B. Civil Action Nos. 78-0584 and 78-0175

While *Humana of South Carolina* was pending Humana and its subsidiaries jointly pursued their administrative remedies concerning reimbursement disputes for the 1973 fiscal year. Between December 15, 1975 and February 28, 1976 the fiscal intermediaries notified plaintiff hospitals that various costs claimed for the cost period ending August 31, 1973 were disallowed. The plaintiffs appealed to the PRRB to contest the fiscal intermediaries' cost disallowances in several areas: (1) costs incurred to acquire new facilities by means of purchasing 100% of the capital stock; (2) cost of federal and state income taxes; and (3) stockholder servicing costs. On December 1, 1977 the PRRB determined: (1) with respect to the stock acquisition issue, seven of plaintiffs' hospitals were not entitled to increased asset valuations and five were entitled to such an increase; (2) Humana was not entitled to consider income tax liability as an allowable cost for reimbursement purposes and was not entitled to exclude income tax liability from the calculation of equity capital; and (3) Humana was entitled to reimbursement for stock maintenance costs. Plaintiffs sought judicial review of the PRRB's decision on the income tax issue which the Administrator had not elected to review. *Humana Inc., et al. v. Califano,* C.A. No. 78-0175.

Subsequently, the Administrator, Health Care Financing Administration ("HCFA") elected to review those issues that

the PRRB had decided in Humana's favor and on January 31, 1978 reversed those portions of the PRRB's decision. Thereafter, plaintiffs sought judicial review of the Administrator's decision (C.A. No. 78-0584). By order of the court on June 8, 1978, C.A. Nos. 78-0175 and 78-0584 were consolidated.

Well after the lawsuits for the 1973 fiscal year were filed, on May 31, 1979 the PRRB issued its decision for identical claims made by Humana for the fiscal years ending in 1974 and 1975. Because the PRRB decided these issues in substantially the same manner as it had the 1973 fiscal year and because it was expected that the Administrator would exercise his authority to reverse those aspects of the PRRB decision favorable to Humana, the Secretary and Humana agreed to consolidate the 1974 and 1975 cost years with the 1973 cost years already before the court. However, it subsequently developed that the Administrator did not act in timely fashion, thus leaving the PRRB decision as the final agency action. On August 14, 1979 Humana amended its complaint to include the 1974 and 1975 fiscal years.

C. Civil Action Nos. 81-0853 and 81-1311

Humana Inc., et al. v. Schweiker, C.A. No. 81-0853, filed on April 10, 1981, and *Humana, et al. v. Schweiker,* C.A. No. 81-1311, filed on June 8, 1981, raise identical issues growing out of 1976 and 1977 claims which were denied by the Administrator.

II. JURISDICTION

The source of subject matter jurisdiction for Medicare reimbursement disputes is 42 U.S.C. § 1395oo(f)(1). *Association of American Medical Colleges v. Califano,* 569 F.2d 101 (D.C. Cir. 1977); *Humana of South Carolina, Inc. v. Califano,* 590 F.2d 1070 (D.C. Cir. 1978). That section, providing for a review of a "final decision of the Board," or a "reversal, affirmance or modification" of the Board's decision by the Secretary, requires exhaustion of administrative remedies as a prerequisite to judicial review. *Id.* at 1078.

While the Secretary does not dispute that the court has jurisdiction to hear C.A. Nos. 78-0584 and 78-0175, he does argue that the court has no jurisdiction to decide the validity of the rate of return on equity regulation. The contention is that plaintiffs made no claims at the administrative level on the matter and, consequently, have not exhausted their administrative remedies as required by 42 U.S.C. 1395oo(f)(1).[1] Plaintiffs argue that they did raise the return on equity issue but that the PRRB and the Secretary declined to consider the issue. The court finds that it has jurisdiction to consider the return on equity issue.

The Secretary makes only a brief argument as to the court's lack of jurisdiction over the return on equity matter. The sole allegation is that "[p]laintiffs did not make a claim in their reports." [2] Since, according to the Secretary, there was no claim at the administrative levels there has been no exhaustion of administrative remedies, and consequently, the court has no jurisdiction. However, as plaintiffs note, the Secretary has taken the opposite position and conceded that the plaintiffs have properly presented jurisdiction in federal court when he urged the court of appeals for this Circuit to dismiss an appeal by one of the plaintiffs.[3] Moreover, the Court of Appeals noted that Humana apparently had asserted federal jurisdiction over the return on equity issue it had before it and, indeed, cited the fact that the Secretary had conceded that "Humana of South Carolina, by its new complaint has now properly presented jurisdiction in the federal district court under 42 U.S.C. § 1395oo." [4]

This court obviously cannot assume jurisdiction merely because both parties have conceded it [5] but only because in fact

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[1] Defendant's Motion for Summary Judgment—Memorandum of Points and Authorities (December 18, 1979) at 8.

[2] *Id.*

[3] Plaintiffs' Reply Memorandum in Support of Summary Judgment (January 15, 1980) at 6.

[4] Humana of South Carolina v. Califano, 590 F.2d 1070, 1084-85 n.105 (D.C. Cir. 1978).

[5] *See* Potomac Passengers Ass'n v. Chesapeake & Ohio Ry Co., 520 F.2d 91, 95 n.22 (D.C. Cir. 1975) (citing Mansfield Calm Ry. Co. v. Swan, 111 U.S. 379, 382 (1884) and Wright & Miller § 1393).

the case is properly presented. The court is convinced by the plaintiffs' contention and proof [6] as well as by the Secretary's earlier concession that plaintiffs did in fact present the issue of the legality of the rate of return on equity issue before the PRRB and that the PRRB and the Secretary refused to discuss the issue. Such a refusal presents a final administrative decision subject to judicial review under § 1395oo.[7]

III. SUBSTANTIVE ISSUES

A. Rate of Return on Equity

Plaintiffs, Humana, contend that the Secretary's regulations (42 C.F.R. § 405.429) limit the return on the equity capital invested in the hospital's operations to a rate too low to reimburse a facility for the cost of attracting capital that the return on equity is intended to reimburse. The Secretary's position is that the rate of return employed is the maximum allowable under the statute and an adequate reimbursement for the reasonable cost of attracting capital to the corporation. This court finds that the Secretary has demonstrated that the rate of return is reasonable.

Plaintiffs argue that the current rate of return is so low that it violates the statutory requirement mandating full reimbursement of a provider's cost, and forces providers to increase their profits at the expense of non-Medicare patients. They cite the court's earlier opinion, *Humana of South Carolina v. Mathews,* 419 F. Supp. 253 (D.D.C. 1976) as evidence that the Secretary's rate was totally arbitrary and apparently too low.[8] At

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[6] *See* Plaintiffs' Motion for Summary Judgment—Exhibit C2 (June 16, 1980) (affidavits of Robert Weinstein, Advisor to the PRRB, and Arthur Owens, Chairman of the PRRB, stating that Humana raised the issue of the legality of the rate of return but PRRB refused to consider it).

[7] Humana of South Carolina, Inc. v. Califano, 590 F.2d 1070, 1078 n.51 (D.C. Cir. 1978) and Order Denying Petition for Rehearing in Humana of South Carolina v. Califano (attached Memorandum), C.A. Nos. 76-1953, 76-2125 (D.C. Cir., filed December 29, 1978) (acknowledging that a refusal to hear a claim may be a final administrative decision subject to judicial review under § 1395oo).

[8] Plaintiffs' Brief in Support of Motion for Summary Judgment (June 16, 1980) at 29-30.

that time, this court determined that the Secretary had not made a formal determination of the adequacy of the rate and specifically noted that it had *not* held the rate inadequate, *Humana, id.* at 262. This court decided that the language of the statute and the brief legislative history did not impose a "one and one half times" limitation on the Secretary's determination of the level of return on equity capital, but did impose an obligation on the Secretary to make a formal determination of the *actual* level of return needed. *Id.* (Emphasis in original.)

The General Accounting Office study [9] presents such a formal determination. This court recognized in its earlier opinion that the Secretary has the institutional competence and expertise to make a determination as to the appropriate rate of return, *Humana, id.*, and so holds that the Secretary's determination must stand.

B. Stock Acquisition

In a number of instances plaintiffs acquired hospital facilities through the purchase of 100% of the stock of the corporations which owned them. In some cases plaintiffs liquidated these corporations, thereby acquiring direct ownership of hospital facilities. In other instances plaintiffs merely took over management and control of the newly acquired corporation and continued its operation of a health care facility. In their claims for reimbursement under the Medicare program plaintiffs calculated their capital costs (depreciation on capital equipment, interest expense on loans to finance the acquisition, and a return on capital invested in the facility) on the basis of the price paid to acquire the corporation owning the hospital. That is to say, in all instances plaintiffs attributed the stock purchase price to the tangible and intangible assets of the acquired corporation, and sought reimbursement on a "stepped-up" basis.

The Secretary consistently interpreted 42 C.F.R. § 405.415(8)(h) to encompass only purchases of actual physical assets, and denied plaintiffs reimbursement claims on the grounds that acquisition of the stock of a previous corporate

[9] *See* Appendix to Defendant's Memorandum of Points and Authorities in Support of Motion for Summary Judgment (December 18, 1979).

owner of a health care facility does not amount to acquisition of its assets. According to the Secretary, under that interpretation of the regulation no difference in treatment should be made between cases where acquired corporations are liquidated and where they are not.

There is little support in the case law for plaintiffs' contention that anything less than liquidation and merger after stock acquisition entitles them to the stepped-up basis. However, plaintiffs strongly urge that even if not in all the cases, their claims certainly should be allowed in instances where liquidation followed the stock purchase, and they cite authority for this proposition. *Pacific Coast Medical Enterprises v. Harris*, 633 F.2d 123 (9th Cir. 1980); *Memorial Inc. v. Harris*, 655 F.2d 905 (9th Cir. 1980); *West Seattle General Hospital, Inc. v. United States*, Medicare & Medicaid Guide (CCH) ¶ 31,874 at 933 (Ct. Cl. March 10, 1982).

Although the precise question (100% stock purchase followed by liquidation) was not before it, our Court of Appeals, in a case involving purchase of 100% of stock followed by something less than dissolution of the acquired corporation, *Richey Manor, Inc., d/b/a Richey Manor Nursing Home v. Richard Schweiker, Secretary of Health and Human Services*, No. 81-1045 (D.C. Cir. 1982) specifically focused on the proposition urged by plaintiffs, and flatly rejected it. And in doing so the court clearly set forth its reasons for not adopting the rationale of those cases which support plaintiffs' position. Accordingly, the Secretary's determination in this regard is affirmed.

C. Federal and State Income Taxes

Plaintiffs, as "for profit" health care institutions, incur liabilities for federal and state income taxes which they argue are reimbursable under the Medicare Act. The Secretary takes the position tax liabilities are not related to patient care under 42 C.F.R. § 405.451 and consequently are not reimbursable. This court finds that the Secretary's determination that income tax liabilities are not related sufficiently to patient care to be reimbursable is not arbitrary or capricious.

Plaintiffs argue that income taxes are ordinary costs of services which must be reimbursed independently of the return on equity and cite a number of Federal Power Commission cases.[10] However, the Medicare case in our Circuit which deals with the issue of taxes, *American Medical International v. Secretary of HEW*, 466 F. Supp. 605 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. Cir. August 14, 1981) (hereinafter "AMI"), holds against the plaintiffs. In *AMI*, Judge Richey determined that franchise taxes based on income, were not reimbursable under the Medicare Act, *AMI, id.* at 624-28. Although *AMI* dealt with franchise taxes, it is directly on point with the issues in the case at bar. The court in that case noted that the key question in determining whether a tax is reimbursable or not is "why is the tax imposed?" *AMI, id.* at 626. The basis for the tax determines whether or not it is a cost incurred in rendering medical services. An income tax, held the *AMI* court, is a cost of making a profit not of providing medical care.

In conjunction with this argument on the question of reimbursement of tax liabilities plaintiffs argue that income tax liability cannot be deducted from the calculation of equity capital unless it is reimbursable. Plaintiffs cite no cases but argue that if income generated from a hospital's operation is not counted as a result if its Medicare operation the income tax liability thereon should not be considered in equity capital.[11] However, plaintiffs apply the guidelines incorrectly. As the *AMI* court explicated, if equity capital is determined upon only investment assets related to patient care, 42 C.F.R. § 405.429(b)(1), then all liabilities not related to patient care, the ones that are *not* reimbursable, are precisely those liabilities that must be subtracted from working capital in order to arrive at a net working capital that only includes assets related to patient care, *AMI, id.* at 627. Consequently, this court, in keeping with *AMI*, holds that the Secretary was neither arbitrary nor capricious in deducting tax liability in the calculation of equity capital.

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[10] *See* Plaintiffs' Reply Memorandum in Support of Motion for Summary Judgment (January 15, 1980) at 14.

[11] *Id.* at 16.

D. Stock Maintenance Costs

Humana and its subsidiaries argue that costs incurred in selling the stock of the corporate hospital to investors (e.g. SEC filing fees, stock transfer fees or costs of stockholder meetings) are indirect but necessary costs of providing health care services. The Secretary contends that stock maintenance costs are incurred for the benefit of investors, are not necessary for providing medical services, and consequently are not reimbursable.

Plaintiffs' position is that since a provider must raise capital to purchase hospital assets and inasmuch as selling stock to investors is a typical method by which capital is raised, the costs of obtaining and maintaining those investments are necessary to provide health care services.[12] They cite *AMI Chanco Inc. v. United States,* 576 F.2d 320 (Ct. Cl. 1978) (hereinafter "AMI Chanco") to support their contention. However, *AMI,* (which the Secretary cites) concludes just the opposite from the holding in *AMI Chanco:* "... the primary purpose of stock maintenance costs is to enhance investment." *AMI, id.* at 615. Our Circuit has clearly adopted this latter interpretation, thus foreclosing plaintiffs' claim in this regard. In its affirmation of the lower court in *AMI,* it specifically addressed the issue of whether the Secretary was estopped from withholding reimbursement of stock maintenance costs given the Court of Claims decision in *AMI Chanco, AMI,* No. 79-1460 (August 14, 1981). The Circuit Court held that it was not bound by the Court of Claims decision, and affirmed the lower court opinion disallowing stock maintenance costs as reimbursable items.

E. Procedural Defects

Humana and its subsidiaries object to the manner in which the requirement policies at issue were promulgated and to the manner in which the Administrator has exercised his decision making authority. Plaintiffs allege that the policies and regulations upon which the Secretary relies to deny the provider-hospitals' reimbursement for stock acquisition costs, income taxes, and stock maintenance costs were all illegally promul-

[12] *Id.* at 27.

gated because they were not subjected to the notice and comment requirements of the Administrative Procedure Act. The Secretary contends that these policies are all interpretive rules, as opposed to substantive rules, and, consequently, are exempted from the notice and comment requirements of the Administrative Procedure Act by 5 U.S.C. § 553(b)(A). This court agrees.

An interpretive rule clarifies or explains existing law or regulations. *Gosman v. United States,* 573 F.2d 31, 39 (Ct. Cl. 1978). The Secretary's policies on stock acquisition costs, stock maintenance costs and income tax liabilities interpret and apply the more general terms of the statute and regulations. The *AMI* court held that this was true as regards stock maintenance costs, *AMI,* 466 F. Supp. at 615-16, and in *Homan & Crimen v. Harris,* 626 F.2d 1201, 1210 (5th Cir. 1978)[13] the court reached the same conclusion as to stock acquisition cost policies.

Plaintiffs also claim that the Administrator illegally delegated his decision making authority to his Attorney-Advisor. They allege that the Administrator did not even review the record in their case but rather adopted the Attorney-Advisor's recommendation without discussion.[14] The Secretary suggests that this court should not attempt to read the mind of the agency head. *United States v. Morgan,* 313 U.S. 409, 422 (1941).

Plaintiffs emphasize that the Administrator adopted the Attorney-Advisor's recommendation without discussing it with her and without making any editorial changes in the recommended decision.[15] None of this suggests that the Administrator did not review the plaintiffs' record. Although it may indicate that, as plaintiffs emphasize, the Administrator did not "really take a hard look" at the issues raised, it is clear that the

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[13] Plaintiffs' cite to *Homan & Crimen* refers to the lower court opinion which was reversed.

[14] Plaintiffs' Reply Memorandum in Support of Motion for Summary Judgment (January 15, 1980) at 31.

[15] Plaintiffs' Brief in Support of Motion for Summary Judgment (June 16, 1980) at 34.

issues Humana raised and the Administrator intended to address[16] were issues that had been addressed by the Administrator and his support staff before. This court will not endeavor to probe the mental processes of the Administrator, and finds no impropriety in his decision in this regard.

IV. CONCLUSION

Plaintiffs, Humana Inc., have raised a variety of substantive and procedural challenges to the method by which the Secretary has calculated reimbursable items under the Medicare Act. As this court has indicated above, most of the challenges have been litigated before and decided adversely to plaintiffs' contentions. As other courts have noted, the matters plaintiffs challenge have been left by Congress to the broad discretion of the Secretary. This court finds that the Secretary's decisions on the issues raised by plaintiffs are not "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A) (1976).

Accordingly, the plaintiffs' motion for summary judgment is denied, and the defendant's motion for summary judgment is granted.

/s/

United States District Judge

Date: August 19, 1982

[16] The Administrator did not review the rate of return question but this was not delegated to a subordinate; the Administrator refused to address the issue at all.

United States District Court

FOR THE DISTRICT OF COLUMBIA

C.A. Nos. 75-0302, 78-0175, 78-0584, 81-0853, 81-1311

HUMANA INC., *et al.*, PLAINTIFFS,

v.

RICHARD S. SCHWEIKER,
SECRETARY, DEPARTMENT OF HEALTH
AND HUMAN SERVICES, DEFENDANT.

ORDER

(Filed August 19, 1982)

For the reasons stated in the accompanying memorandum, it is hereby

ORDERED that plaintiffs' motion for summary judgment is denied, and the defendant's motion for summary judgment is granted.

/s/

United States District Judge

Date: August 19, 1982

APPENDIX D

Health Care Financing Administration

Decision of the Administrator

In the Case of:

HUMANA GROUP APPEAL III
Provider

vs.

BLUE CROSS ASSOCIATION/VARIOUS BLUE CROSS PLANS AND INTERMEDIARIES
Intermediary

Claim for:

Provider Cost Reimbursement
Determination of Reasonable Costs
for Cost Reporting Period(s) Ending
August 31, 1976 and
August 31, 1977

Review of:

PRRB Decision No. 81-D12
Dated: February 5, 1981

This group appeal is before the Deputy Administrator, Health Care Financing Administration, for review of the decision of the Provider Reimbursement Review Board. The review is during the 60-day period in Section 1878(f) of the Social Security Act, as amended [42 USC 1395oo]. Comments were received from the Division of Institutional Services Reimbursement and from the Intermediaries requesting reversal, in part, of the Board's decision on Issue Nos. 1 and 3, and reversal of Issue No. 2c. On February 27, the parties were notified of the intent to review the Board's decision on Issue Nos. 1 and 3 in light of the Administrator's action on Issue Nos. 1 and 3 of PRRB Decision No. 77-D89 for the same Providers' previous cost year ending August 31, 1973. They were also notified of the intent to review Issue No. 2c. The Providers

requested that Issue Nos. 1 and 3 be affirmed in part and reversed in part, and that Issue No. 2c be affirmed. Accordingly, the case is now before the Deputy Administrator for final administrative decision.

ISSUE[S] . . . AS STATED BY THE BOARD

* * *

"2. c. Are taxes assessed on the Providers' net income derived from its participation in the Medicare program allowable under the terms of the Medicare Law and Regulations?"

"3. Are stock maintenance expenses incurred by the Providers and/or allocated to them by their Parent Corporation allowable under costs under the terms of the Medicare Law and Regulations?"

* * *

DISCUSSION AND EVALUATION

The entire record which was before the Provider Reimbursement Review Board has been examined, including all position papers and exhibits submitted by the parties and the Joint Stipulation. The Board's decision on the record has been carefully reviewed. The comments received after entry of the Board's decision have been made a part of the record and considered.

* * *

Issue No. 2c

The Board held that the Parent Company is entitled to reimbursement for the income taxes assessed on the Providers' net income derived from their participation in the Medicare program through payment of a return on equity capital. Essentially, the effect of this decision is to allow as a reimbursable cost income taxes paid by these proprietary Providers.

Medicare is a cost reimbursement program. Section 1811 of the Social Security Act, as amended [42 USC 1395c], shows

it was established as an insurance program to protect its beneficiaries against the costs of hospital and related post-hospital services. To this end, Medicare reimburses providers of services the reasonable cost incurred in furnishing needed health care to Medicare beneficiaries. In the case of proprietary providers, Medicare also pays a reasonable return or profit on the net equity used in furnishing care to Medicare beneficiaries.

The reasonable cost for program reimbursement purposes is defined in Section 1861(v)(1)(A) of the Social Security Act, as amended [42 USC 1395x]. This section requires that "reasonable cost . . . be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items included. . ." Taxes paid by providers are not incurred costs necessary in the efficient delivery of needed health services. As such, these costs are not costs of directly rendering patient care and are not a result of costs incurred, but are a result of the revenue these proprietary hospitals receive.

42 CFR 405.451 also imposes a strict definition on reasonable costs related to patient care. 42 CFR 405.451(a) states that "all payments to providers of services must be based on the reasonabe cost of services covered under Title XVIII of the Act and related to the care of beneficiaries . . ." Thus, under 42 CFR 405.451(c)(3), "The determination of reasonable cost of services must be based on cost related to the care of beneficiaries of Title XVIII of the Act."

The Providers seek to be reimbursed by Medicare by citing that their claim is supported by generally accepted accounting principles. They wish to make taxes on a provider's return on equity a separate Medicare cost which should be reimbursed. While generally accepted accounting principles may recognize income taxes as a cost, this does not establish the Medicare program's policy in excluding them. They are not regarded as a reimbursable cost for Medicare reimbursement purposes.

The payment of taxes by proprietary hospitals are not costs related to the care of beneficiaries as required under the Law

and Regulations. Even though a portion of these taxes are derived from the Providers' return on equity capital, the payments of them are related only to the Providers' earnings and profits. The Providers' return on equity capital is not recognized as an element of cost to providers, but instead as an element of profit. If Medicare were to reimburse the income taxes claimed on the allowable return, Medicare would be paying an amount in excess of its share of reasonable costs. This excess would be used to satisfy the burden of non-Medicare patients, contrary to the mandate in Section 1861(v)(1)(A) of the Act against Medicare paying a disproportionate share of a provider's costs.

Nevertheless, patient care services may be rendered regardless of tax liability. It is the nature of proprietary providers which ultimately gives rise to the payment of income taxes. As for-profit institutions, these providers can expect to pay income taxes which is related solely to their income and not to the patient care rendered Medicare beneficiaries.

The Board is authorized, under Section 1878(e) of the Social Security Act, as amended [42 USC 1395oo], to make rules and establish procedures not inconsistent with the Medicare law and regulations. The Regulation, 42 CFR 405.1867, likewise requires the Board to comply with all the provisions of the Act and the Regulations. This Regulation also requires the Board to afford great weight to interpretive rules and general statements of policy.

In that regard, Section 2122.2 of the Provider Reimbursement Manual (HIM-15) restates longstanding policy as interpreted through the Law and Regulations that the payment of income taxes is not related to the care of beneficiaries. This section specifically provides that Federal, State, and local income taxes are not allowable costs. The Board's decision allowing these income taxes circumvents the Law, Regulations and general policy.

In this case, it is clear that § 2122.2 was issued to interpret the reimbursement regulations. Section 2122.2 of the Provider Reimbursement Manual (HIM-15) does not change the basic

policy regarding the exclusion of income taxes from allowable costs. To the contrary, this provision is an interpretation and clarification of the Regulations.

The Board cited in support of its decision 42 CFR 405.429. This Regulation allows a reasonable return on equity capital invested and used in the provision of patient care as an element of reasonable cost of proprietary providers. The Board held that reimbursement generated by the equity capital provision of the Medicare program should not be reduced by the payment of the equity capital portion of income taxes. The Board concluded that the disallowance of that portion of income taxes which are directly related to patient care (equity capital) defeats the purpose of 42 CFR 405.429.

The Deputy Administrator disagrees with this conclusion by the Board. The reasonable return on equity capital which is allowed to proprietary providers is allowed in lieu of profit. As such, it is the equivalent of income or revenue for these Providers and should be expected to be taxes accordingly. Providers cannot expect the Medicare program to increase reimbursement to proprietary hospitals on the theory that they are being penalized by the government because a portion of their return on equity capital is reduced by taxes. If the Providers had realized an equivalent return on their investment from other sources, there would be no question that the income realized would be taxed.

The same treatment should be expected as to the Providers' return on equity capital which is given in lieu of profit. If Medicare were to allow an exception to the prohibition against reimbursement for income taxes as they pertain only to a provider's return on equity capital, then these proprietary Providers would in effect be reimbursed twice—once for the allowable return on equity capital and again for the income taxes on this return. This was not the intent of 42 CFR 405.429. There is nothing in this Regulation which permits payment for more than the specified rate of return. The Board's decision allowing a portion of income taxes as allowable cost because the Providers' equity capital payment is subject to taxation creates an increase in the equity capital payment in excess of

that mandated by 42 CFR 405.429. As already noted, any such increase would result in Medicare paying for the costs of non-Medicare patients, contrary to the provisions in Section 1861(v)(1)(A) of the Act.

The Deputy Administrator agrees with the dissenting opinion of the Board Chairman that Medicare's recognition of a reasonable return on the net equity of a proprietary provider does not allow a provider to ignore the specific exclusion of income taxes from allowable costs. As stated by the Board Chairman, "[t]he principle that 'income taxes are not allowable costs' applies to the 'taxes' not the source of the income." The Board's decision has created an exception to this exclusion which is not warranted by the Law, Regulations or Medicare program policy.

Issue No. 3

The Board held that stock maintenance costs in the amounts of $98,102 and $463,207 for the 1976 and 1977 cost years, respectively, are not allowable because they are not directly or indirectly related to patient care. The Board also held, however, that the remaining stock maintenance costs pertaining to stockholder relations, annual reports and stock transfer agreements are indirectly related to patient care and are allowable.

The Board noted in its decision that the facts in this issue are essentially the same as in the two previous decisions, Decision Nos. 77-D89 and 79-D31, involving the Providers' prior cost years. In those decisions, the Board allowed all of the stock maintenance costs claimed. The Board's decision in the current case disallowing most of the stock maintenance costs claimed is not based on any new evidence. Nevertheless, it allows without detailed explanation these costs based on the Board's conclusion that these costs are not related to patient care.

The Deputy Administrator agrees with the Board's decision disallowing the majority of these stock maintenance costs as not being related to patient care. However, the Deputy Administrator continues to believe that none of the stock

maintenance costs claimed are related to patient care and are thus not allowable. The dissenting opinion by the Board Chairman correctly noted that all stock maintenance costs are incurred primarily for the benefit of stockholders.

The Providers' comments that certain stock maintenance costs are necessary for the Providers' continued legal existence and, in turn, indirectly related to the delivery of patient care services have been noted. It is recognized that some stock maintenance costs are necessary for a publicly held corporation to maintain its corporate status; however, these costs are not "related to the care of beneficiaries . . ." as requried by 42 CFR 405.451(a). The reference to a previous action by the Administrator which did not effectively reverse a Board decision upholding the allowability of stock maintenance costs is erroneous. The Deputy Administrator's reversal as to the Providers' previous cost year (PRRB Decision No. 79-D31) was withdrawn by the Administrator for procedural reasons only.

As to the procedural matter raised by the Providers in their comments, the Deputy Administrator does not agree with the Providers' claim. A review of the record does not indicate that the executive salaries disallowed by the Board were not a part of the appeal. The executive salaries were excluded by the Intermediary by audit adjustments to the Parent Company's home office expenses prior to allocation to the Providers. This issue was decided on the record. The hearing referred to by the Providers dealt with another issue which is not the subject of this review. A careful review of the transcript of that hearing does not disclose any mention of executive salaries as part of the disallowed stock maintenance costs.

The scope of the Board's decision-making authority is set forth in Section 1878(d) of the Social Security Act, as amended [42 USC 1395oo] and in 42 CFR 405.1869. This Regulation established that the Board has the power to affirm, modify, or reverse a determination of an intermediary with respect to a cost report and make any other determinations with respect to matters covered by a cost report even if not considered in the Intermediary's determination. The Providers' assertion that the

Board's decision concerning executive salaries was improperly considered, is not supported by the facts in this case or by the Regulation. The executive salaries were a part of the stock maintenance costs being appealed and were properly considered by the Board.

The Board's decision allowing the stock maintenance costs pertaining to stockholder relations, legal fees for SEC and State filings, accounting fees for SEC filings, travel expense related to SEC, and travel expenses of the legal department related to registration are not related to patient care and are not allowable.

Accordingly, after thorough review of the decision of the Administrator dated January 31, 1978, reviewing Issue No. 3 of PRRB Decision No. 77-D89, no error has been found. The pertinent discussion applicable to the present appeal are the same as those considered by the Administrator in the previous decision. Therefore, the complete Discussion and Evaluation contained in the Administrator's prior decision is incorporated by reference and adopted as to this decision.

Issues Nos. 2a, 2b, and 4

The Deputy Administrator has considered the Providers' request for review of Issue Nos. 2a, 2b, and 4. The record indicates that the Providers received a copy of the Board's decision on February 9. However, the Providers' request for review of these issues was not received until March 17. Since the comments concerning these three issues were submitted well after the 15-day time limit in which to initiate a request for review under Section (5)(b)(1) of the Interim Procedures (42 FR 44599, September 6, 1977) these comments were not considered. The Providers had knowledge of the review procedures because the Board furnished them a copy of the Interim Procedures as an attachment to its decision. Further, the Providers and their representative are familiar with these procedures having previously had various cases on final agency review.

The law permits only 60 days for the entire review process. Because of this limited time for review, the Interim Procedures

place stringent time limits for initiating review by a request for review. This is necessary in order to afford the Administrator the opportunity to conduct a proper review of the records and evidence in light of the parties' comments, and to afford the other parties an adequate opportunity to respond. Accordingly, the Providers' request for review in this case on Issue Nos. 2a, 2b, and 4 has not been considered.

FINDINGS OF FACT

1. The amount of Medicare reimbursement in dispute exceeds $50,000 for the 1976 and 1977 cost years at issue.

* * *

Issue No. 2c

6. All of the Providers at issue are acute-care proprietary hospitals and wholly-owned subsidiaries of the Parent Company, Humana Inc.

7. These Providers claimed and received payment of a return on equity capital.

8. The Providers paid State and Federal income taxes on the revenue received as their allowable return on equity capital.

9. The Parent Company included as part of its home office expenses the income taxes paid by the Providers related to their return on equity capital.

10. The Intermediaries disallowed Medicare reimbursement for the Parent Company's claim for the income taxes assessed on the Providers' return on equity capital payments prior to allocation of these expenses to the Providers.

Issue No. 3

11. The complete statement of Findings of Fact contained in Issue No. 3 in the Administrator's review of PRRB Decision No. 77-D89 is incorporated by reference and adopted as to this decision.

12. Medicare reimbursement for the stock maintenance costs incurred by the Parent Company, Humana Inc., during the fiscal years ending August 31, 1976, and 1977 are in dispute.

13. The Parent Company claimed its stock maintenance costs prior to the allocation to the Providers in appeal on this issue.

14. The Providers did not receive any health care services, facilities, or supplies for the stock maintenance costs incurred by the Parent Company.

15. The stock maintenance costs were incurred by the Parent Company to maintain its equity and corporate status.

16. The Intermediaries disallowed Medicare reimbursement for the Parent Company's stock maintenance costs prior to allocation of the costs.

CONCLUSIONS OF LAW

* * *

Issue No. 2c

14. Reimbursement for income taxes paid on revenue received as part of the Providers' return on equity capital is not necessary in the efficient delivery of needed health services under Section 1861(v)(1)(A) of the Social Security Act, as amended [42 USC 1395x].

15. The payment of taxes on the Providers' revenue received as a return on equity capital is not reimbursable to the Parent Company as an element of reasonable cost under Section 1861(v)(1)(A) of the Social Security Act, as amended [42 USC 1395f and x], and 42 CFR 405.451.

16. The payment of taxes by the Providers are not costs related to the care of beneficiaries as required of reimbursable costs under 42 CFR 405.451.

17. The Providers are not entitled to payment for more than the specified rate of return on equity capital unbder 42 CFR 405.429.

18. Reimbursement for income taxes assessed on the revenue received by the Providers as payment for their return on equity capital is an improper increase in the Providers' equity capital payment not mandated by 42 CFR 405.429.

19. Reimbursement to the Parent Company for the income taxes paid on revenue received as a return on equity capital is not an allowable cost under 42 CFR 405.451, as interpreted by 2122.2 of the Provider Reimbursement Manual.

Issue No. 3

20. The complete statement of Conclusions of Law contained in Issue No. 3 in the Administrator's review of PRRB Decision No. 77D89 is incorporated by reference and adopted as to this decision.

21. The Parent Company and the Providers are organizations related by control within the meaning of 42 CFR 405.427(a) and (b)(3).

22. The Parent Company's stock maintenance costs did not constitute services, facilities, and supplies furnished by a related organization under 42 CFR 405.427(a) or Section 1861 of the Act [42 USC 1395x].

23. Not representing services, facilities, and supplies furnished by a related organization, the Parent Company's stock maintenance costs are not includable in the allowable costs of the Providers under 42 CFR 405.427(a).

24. The Parent Company's stock maintenance costs are not necessary for the Providers' efficient delivery of services covered by Medicare under Section 1861(v)(1)(A) of the Social Security Act, as amended [42 USC 1395x].

25. The Parent Company's stock maintenance costs do not represent reasonable costs of services covered by Medicare and related to the care of beneficiaries as required by 42 CFR 405.451(a).

26. Medicare funds may not be used to reimburse the Providers for the stock maintenance costs under 42 CFR 405.451(a).

27. The Parent Company's stock maintenance costs are not necessary and proper costs appropriate and helpful in patient care activities, neither are they common and accepted occurrences in the field of the Providers' activities as required by 42 CFR 405.451(b)(2).

28. The claimed stock maintenance costs of the Parent Company are specifically excluded from program reimbursement and in excess of costs necessary for needed health services under 42 CFR 405.451(c)(3) as interpreted by § 2134.9 and § 2150.2B.1 of the Provider Reimbursement Manual (HIM-15).

29. The return on the Providers' equity capital invested and used for patient care is the only cost permitted for investment under 42 CFR 405.429(a).

30. Being costs related to the Parent Company's investment, the Parent Company's stock maintenance costs are not reasonable costs related to patient care under Section 1861(v)(1)(B) of the Social Security Act, as amended [42 USC 1395x].

DECISION

* * *

Issue No. 2

The Board's decision on Issue Nos. 2a and 2b is affirmed. Income taxes cannot be considered an allowable cost in order to make the rate of return on equity capital an after-tax return. Income tax liability must be included in the determination of equity capital.

The Board's decision on Issue No. 2c is reversed. The Parent Company is not entitled to claim as a home office expense income taxes paid on revenue received as payment for the Providers' return on equity capital.

Issue No. 3

The Board's decision disallowing those stock maintenance costs in the amounts of $98,102 and $463,207 is affirmed. The Board's decision allowing a portion of the stock maintenance costs incurred by the Parent Company is reversed. Stock maintenance costs are not allowable.

* * *

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 4/3/1981

/s/ PAUL R. WILLGING, PH.D.

Paul R. Willging, Ph.D.
Deputy Administrator
Health Care Financing
Administration

APPENDIX E

Provider Reimbursement Review Board

Hearing Decision

81-D12

Provider—Humana Group Appeal III

Provider Nos. Various

Intermediary—Blue Cross Association/Various Blue Cross Plans and Intermediaries

Date of Hearing—July 31, 1980

Date of Hearing on Record—September 15, 1980

Case No. 78-359G

* * *

ISSUES:

* * *

2. a. Is income tax expense an allowable cost?

   b. Should tax liabilities be included in the calculation of equity capital?

   c. Are taxes assessed on the Providers' net income derived from its participation in the Medicare program allowable under the terms of the Medicare Law and Regulations?

3. Are stock maintenance expenses incurred by the Providers and/or allocated to them by their Parent Corporation allowable costs under the terms of the Medicare Law and Regulations?

* * *

SUMMARY OF FACTS:

Humana Inc., hereinafter referred to as the Parent Company, with its subsidiaries are engaged in the development, ownership and operation of hospitals. The Intermediaries audited the Parent Company and its subsidiaries for the 1976

and 1977 cost years and made several adjustments pertaining to the aforesaid four issues and two subissues which involve approximately $5,658,000 of Medicare reimbursement. The Parent Company did not accept the Intermediaries' adjustments and filed a timely request for a hearing before this Board. Issue No. 4 is the only one in which oral arguments were presented by the parties on July 31, 1980, the remaining issues were considered at a hearing on the record September 15, 1980. For the sake of brevity, and since Issue No. 1, Issue No. 2a and 2b and Issue No. 3 have been before this Board and *Decisions 77-D89 and 79-D31* rendered pertaining to the aforesaid issues; this Board makes full reference and does incorporate the complete record of the prior two decisions. A listing of Intermediaries and Providers can be found in the Intermediaries' position paper.

* * *

CONCLUSIONS AND FINDINGS:

The Provider Reimbursement Review Board, after consideration of the facts, parties' contentions, testimony given at the hearing and evidence presented concludes and finds as follows:

* * *

Issue No. 2a and 2b

The Board finds that the Intermediaries' adjustments are correct. The facts in the instant case as they pertain to the subject issues are essentially the same as those cited in *Board Decisions 77-D89 and 79-D31.* In those two prior decisions, the Board found:

2a. The Provider is not entitled to consider income taxes as an allowable cost. (Except for—see Issue 2c below.)

2b. The income tax liability must be included in the determination of equity capital.

Issue No. 2c

The majority of this Board finds that the Parent Company is entitled to reimbursement for the income taxes assessed on the Providers' net income derived from their participation in the Medicare program (equity capital). The Board majority notes that "a reasonable return on equity capital invested and used in the provision of patient care is *allowable as an element of the reasonable cost* of covered services furnished to beneficiaries by proprietary providers" as provided under the terms of § 405.429 of the Regulations. (Emphasis Added) On the other hand, the Internal Revenue Service and other taxing authorities do not recognize the return on equity capital as an element of cost, but treat it as "revenue" and tax it accordingly. An identifiable portion of the provider's income tax liability is directly traceable to the return on equity capital payment made to a provider. Since Medicare reimbursement for the return on equity capital is not offset by a corresponding expense, the taxable income of the Provider is increased by the exact amount of the equity payment. Thus, the Provider's income tax liability is increased as a direct result of this provision.

The Board also notes that § 405.429 goes on to say that "proprietary providers generally do not receive public contributions and assistance of Federal and other governmental programs in financing capital expenditures. Proprietary institutions historically have financed expenditures through funds invested by owners in the expectation of earning a return. A return on investment, therefore, is needed to avoid withdrawal of capital and to attract additional capital needed for expansion." Thus, the clear intent of the subject Regulation is to provide proprietary providers with a return on their equity investment for those assets related to patient care and to avoid withdrawal of capital and to encourage additional capital needed for expansion. Reimbursement generated by the equity capital provision of the Medicare program should not be reduced by the payment of the equity capital portion of the income taxes. The Board majority finds that the Intermediary's disallowance of that portion of income taxes which are indirectly related to patient care (equity capital) defeats the purpose of § 405.429 of the Regulations.

Issue No. 3

The Intermediaries' adjustments are modified. The facts in the instant case as they pertain to the subject issue are essentially the same as those cited in ***Board Decision 77-D89 and 79-D31.*** However, the Board finds that there is not substantial evidence to demonstrate that the following costs are directly or indirectly related to patient care as provided under the terms of § 405.451 or 405.453 of the Regulations.

1976 Cost Year

Adjustment Number	Type of Expense	Amount
Humana	Communications Department—Time spent with annual reports, activities related to investor relations, public awareness and community relations of the hospitals	$36,405
13	Correction of Humana's adjustment	$57,797
17	Executive salaries related to stockholder relations	$ 3,900
		$98,102

1977 Cost Year

Adjustment Number	Type of Expense	Amount
Humana	Communications Department—Time spent with annual reports, activities related to investor relations, public awareness of and community relations of the hospitals	$140,733
10	Correction of Humana's adjustment	$230,311
13	Legal fees related to stock maintenance	$ 50,291
15	Brokerage firm fees related to SEC	$ 24,147
19	Executive salaries related to stock maintenance	$ 17,725
		$463,207

The Board majority finds the remaining amounts of stock maintenance costs are indirectly related to patient care and therefore allowable.

* * *

DECISION:

* * *

Issue No. 2

a. The Parent Company is not entitled to consider income taxes as an allowable cost (except for—see Issue 2c herein). The Intermediaries' adjustments are affirmed.

b. The income tax liability must be included in the determination of equity capital. The Intermediaries' adjustments are affirmed.

c. The Parent Company is entitled to reimbursement for the income taxes assessed on the Providers' net income derived from their participation in the Medicare program (equity capital). The computation of the allowable portion of income taxes is computed as follows. The allowance on the return on equity capital times the average income tax rate assessed limited to the lesser of the amount of the computation or the actual income tax. The Intermediaries' adjustments are reversed.

Issue No. 3

The stock maintenance costs of $98,102 and $463,207 for the 1976 and 1977 costs identified in the conclusions and findings herein are not allowable. The remaining amounts claimed by the Parent Company are indirectly related to patient care and therefore allowable. The Intermediaries' adjustments are modified.

* * *

Board Members Participating

Thomas M. Tierney (Dissenting on Issues No. 2c and 3)
Carolyn B. Lewis
H. Hoseph Curl
James Houdek, Jr., CPA
Bette Kraus

FOR THE BOARD

February 5, 1981

/s/ THOMAS M. TIERNEY
Thomas M. Tierney
Chairman

Dissenting Opinion of Thomas M. Tierney

I dissent from the majority opinion as to Issues No. 2c and 3.

Issue No. 2c

The Board has correctly stated, in my opinion, that income taxes are not an allowable cost (Issue No. 2a). There is nothing in the Regulations or the reimbursement manual which would direct going behind that accepted exclusion and ferreting out some portion of a provider's total taxable income which could possibly result from Medicare's recognition of a reasonable return on the net equity of a proprietary provider. The principle that "income taxes are not allowable costs" applies to the "taxes" not the source of the income.

Issue No. 3

In my opinion, the same reasoning applies to Issue No. 3. The basic principle is that "stock maintenance costs" are not allowed. They are deemed to be incurred primarily for the benefit of stockholders whether mandated by a regulatory agency or not.

/s/
Thomas M. Tierney

APPENDIX F

Health Care Financing Administration

Decision of the Administrator

In the Case of:

HUMANA INC. GROUP APPEAL
Provider

VS.

BLUE CROSS ASSOCIATION/VARIOUS BLUE CROSS PLANS
Intermediary

Claim for:

Provider Cost Reimbursement
Determination of Reasonable Costs
for Cost Reporting Period(s) Ending
August 31, 1974, 1975, 1976 and
May 31, 1975

Review of:

PRRB Decision No. 79-D31
Dated: May 31, 1979

The decision of the Administrator in this appeal dated July 30, 1979, is hereby withdrawn on the ground that it was untimely entered.

Date: August 16, 1979

/s/ LEONARD D. SCHAEFFER
Leonard D. Schaeffer
Administrator
Health Care Financing
Administration

APPENDIX G

Health Care Financing Administration
Decision of the Administrator

In the Case of:

HUMANA INC. GROUP APPEAL
Provider

vs.

BLUE CROSS ASSOCIATION/VARIOUS
BLUE CROSS PLANS
Intermediary

Claim for:

Provider Cost Reimbursement
Determination of Reasonable Costs
for Cost Reporting Period(s) Ending
August 31, 1974, 1975, 1976
and May 31, 1975

Review of:

PRRB Decision No. 79-D31
Dated: May 31, 1979

This group appeal is before the Administrator, Health Care Financing Administration, for review on his own motion of the decision entered on May 31, 1979, by the Provider Reimbursement Review Board. This review is undertaken pursuant to Section 1878(f)(1) of the Social Security Act, as amended [42 USC 1395oo]. . . .

* * *

Issue Nos. 2A and 2B

The Board found that the evidence and the arguments presented on these issues are essentially the same as in its Decision No. 77-D89 for the 1973 cost year. On Issue No. 2A the Board held that the Parent Company, Humana Inc., is not

entitled to consider income taxes as an allowable cost in order to make the rate of return on equity capital an after-tax return. As to Issue No. 2B, the Board held that the income tax liability must be included in the determination of equity capital.

The Administrator affirms the Board's decision on these issues. The Conclusions and Findings of the Board are incorporated by reference and adopted as to these issues.

Issue No. 3—Stock Maintenance Costs

The Board held that the Parent Company's stock maintenance costs are allowable costs and that these costs are not covered by the return of equity capital. After thorough review of the previous decision of the Administrator dated January 31, 1978, reviewing PRRB Decision No. 77-D89, no error has been found. The pertinent facts and law applicable to the present appeal are the same as those considered by the Administrator in the previous decision. Therefore, the complete Statement of Evidence Considered; Citation of Law, Regulations, and Other Governing Criteria; Discussion and Evaluation; Findings of Fact; and Conclusions of Law contained in the Administrator's prior decision are incorporated by reference and adopted as to this decision. Accordingly, the decision of the Board on Issue No. 3 is reversed. The stock maintenance costs incurred by the Parent Company and allocated to the Providers are not allowable.

* * *

DECISION

* * *

Issue No. 2

The Board's decision on Issue No. 2 is affirmed. Income taxes cannot be considered an allowable cost in order to make the rate of return on equity capital an after-tax return. Income tax liability must be included in the determination of equity capital.

Issue No. 3

The Board's decision on Issue No. 3 is reversed. The stock maintenance costs incurred by the Parent Company and allocated to the Providers are not allowable.

* * *

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Date: July 30, 1979

/s/ LEONARD D. SCHAEFFER

Leonard D. Schaeffer
Administrator
Health Care Financing
Administration

APPENDIX H

Provider Reimbursement Review Board

Hearing Decision

79-D31

Provider—Humana Inc. Group Appeal

Provider Nos. Various

vs.

Intermediary—Blue Cross Association/Various Blue Cross Plans (See Attachment)

Date of Hearing—December 5 and 6, 1978 and Hearing on the Record

Cost Reporting Period Ending
August 31, 1974
May 31, 1975
August 31, 1975
August 31, 1976

Case No. 77-217G

* * *

ISSUES:

2.A Whether taxes assessed on a provider's net income derived from its participation in the Medicare program are allowable under the terms of the Medicare Law and Regulations?

2.B Whether tax liabilities are to be included in the calculation of equity capital?

3. Whether stock maintenance expenses incurred by the Providers and/or allocated to them by its Parent Corporation are allowable costs under the terms of the Medicare Law and Regulations? *(2)

* * *

STATEMENT OF FACTS—GENERAL:

The Providers hereinafter referred to as the Parent Company, which with its subsidiaries (59 hospitals) are engaged in the development, ownership and operation of hospitals located primarily in the southern and southwestern United States. The Parent Company was incorporated under the laws of the State of Delaware in 1964 to succeed to a business that commenced operation in 1961. The Intermediaries audited the Parent Company and its subsidiaries for the cost years in dispute and issued Notices of Program Reimbursement. The Parent Company and the Provider's, disagreeing with the adjustments pertaining to the four issues, which involve approximately $2,553,000 of Medicare reimbursement, filed timely hearing requests before the Provider Reimbursement Review Board. . . .

* * *

STATEMENT OF FACTS

Issue No. 2A and 2B—Income Taxes and Income Tax Liability and Equity Capital

The Parent Company and certain of the Providers included as a cost in their cost reports the amount of income taxes (for the most part Federal Income Taxes). The Intermediary disallowed this cost with a resulting reduction in Medicare reimbursement of approximately $843,472 for the 1974 cost year and $771,720 for the 1975 cost year. The major proportion of the amounts disallowed were the aggregate Federal Income Taxes included in Home Office Costs and allocated to the Providers. After disallowance of the tax portion of Home Office Costs, the allocations were appropriately adjusted. It is these adjustments that are being appealed by the Parent Company on behalf of the Providers.

* * *

CONCLUSIONS AND FINDINGS:

The Provider Reimbursement Review Board, after consideration of the facts, parties' contentions, the evidence presented

and briefs submitted subsequent to the hearing concludes and finds that in the instant case there is substantial evidence and justification to adopt the same conclusions and findings it reached in its earlier decision 77-D89 for the 1973 cost year. The Board is of the opinion that the evidence and argumentation in the instant case is essentially the same as presented in its earlier decision.

DECISION:

Issue No. 2A—Income Taxes

The Board finds that the Parent Company is not entitled to consider income taxes as an allowable cost in order to make the rate of return on equity capital an after-tax return. The Intermediary's adjustments on this issue are affirmed.

Issue No. 2B—Income Tax Liability and Equity Capital

The income tax liability must be included in the determination of equity capital.

Issue No. 2A—Income Tax

FOR THE BOARD Arthur P. Owens

Majority—Issue 2B—Income Tax Liability and Equity Capital

Arthur P. Owens
Carolyn B. Lewis

Arthur P. Owens

Dissenting Opinion of Harold Hinderer

Issue No. 2B—Income Tax Liability and Equity Capital

In previous Provider Reimbursement Review Board Decisions 76D25, 76-D63, and 77-D61, this member agreed with the Provider's argument that liabilities for income taxes should not be deducted from assets in the computation of the return on equity. Accordingly, we find the same opinion as rendered in 76-D25, 76-D63, and 77-D61, 77-D89, to be appropriate in the instant case.

The incurring of any liability is accompanied by the simultaneous happening of one or a combination of the following events:

(1) an asset is acquired

(2) another liability is reduced

(3) capital (owner's equity) is reduced.

In this case, neither party contends that an asset was acquired. Nor does either party contend that another liability was reduced. Instead, both parties agree that an accounting reduction in capital was concomitant with the recording of the income tax liability.

A reduction of capital can be classified as: a return to shareholders of invested capital (capital dividends); a distribution of earnings (dividends); a reduction of revenue; or, an expense ('cost' in the Medicare program). Clearly, the incurring of a liability for income taxes is not related to the returning of invested capital; the distribution of earnings; or, the reducing of revenue. By elimination, the incurring of a income tax liability which gave rise to the cost *is* related to patient care.

Section 1202.1 of the Provider Reimbursement Manual (HIM-15) would seem to be quite clear where it states: "In effect, equity capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicare program), adjusted for those assets and liabilities which are not related to the provision of patient care."

Section 2171 on which the Board relies, at least in part, for its decision appears to be an attempt to avoid the requirements of the Administrative Procedure Act. The BHI has published a dictum with no rationale to support it. To give such a dictum credence is regrettable. The Board's attempt to apply the matching concept to assets and liabilities rather than to revenue and expense alone is a bold one indeed. The accounting literature is sparse in support of the Board's stance.

The program's liability for income taxes differs from other liabilities which give rise to expenses. Liabilities for income

taxes of any kind should not be deducted from assets in the computation of return on equity unless the tax expense which results from the incurring of these liabilities is allowed as a reimbursable cost.

/s/ HAROLD HINDERER
Harold Hinderer

STATEMENT OF FACTS:

Issue No. 3—Stock Maintenance Costs

After audit of the Parent Company's home office, the Intermediary disallowed expenses of $303,551 and $119,847 for the 1974 and 1975 cost years respectively, generally referred to as "stock maintenance costs," which had been allocated to the Providers in proportion to the expenses of each. The nature and identity of these disallowed expenses pertained to: legal and accounting services involved in SEC filings, stockholder relations such as annual meetings and reports, certain employee publications, stock transfer agent fees, and amortization of trademark costs. The Intermediary relied on § 2134.9 (stockholder servicing costs) and § 2136.2 (advertising costs) of the Provider Reimbursement Manual (HIM-15) as a basis for its disallowances. The above mentioned adjustments reduce Medicare reimbursement in the amounts of $75,436 and $61,111 for the 1975 and 1976 cost years respectively.

* * *

CONCLUSIONS AND FINDINGS:

The Provider Reimbursement Review Board, after consideration of the facts, parties' contentions and evidence presented, concludes that in the instant case, there is substantial evidence and justification to reverse the Intermediary's adjustment. The Parent Company's stock maintenance costs are allowable costs and these costs are not covered by the return of equity capital.

The Board once again reverses the Intermediary's adjustments. The Board makes full reference and does incorporate

the unanimous opinion in *Hearing Decision 77-D89* as its conclusions and findings for the cost years at hand.

DECISION:

The disallowances by the Intermediary of "Stock Maintenance Costs" (Stock Servicing Costs) are reversed. These costs are related indirectly to patient care and are not covered by the rate of return on equity capital. To the extent that the Parent Company engages in activities other than covered patient care services, only that portion of stock maintenance costs relating to covered patient care services would be allowable. Further, the reasonableness of trademark related costs should be given special consideration in relation to he magnitude of total costs.

Moreover, because of the variable magnitude of these costs and the possibility of unreasonable costs, the Board instructs the Intermediary to make sure that the allowed "Stock Maintenance Costs" (Stockholders Servicing Costs) are reasonable and, by comparing the costs with other companies in the same or a related field, are cos.s which would be incurred by a prudent buyer.

FOR THE BOARD:

/S/ ARTHUR P. OWENS

Arthur P. Owens, Chairman

* * *

SUMMARY OF DECISIONS:

Issue No. 2A—Income Taxes

The Board finds that the Parent Company is not entitled to consider income taxes as an allowable cost in order to make the rate of return on equity capital and after-tax return. The Intermediary's adjustments on this issue are affirmed.

Issue No. 2B—Income Tax Liability and Equity Capital

The income tax liability must be included in the determination of equity capital.

Unanimous Decision—Issue No. 2A Majority—Issue No. 2b

Arthur P. Owens
Carolyn B. Lewis

Issue No. 3—Stock Maintenance Costs

The disallowances by the Intermediary of "Stock Maintenance Costs" (Stock Servicing Costs) are reversed. These costs are related indirectly to patient care and are not covered by the rate of return on equity capital. To the extent that the Parent Company engages in activities other than covered patient care services, only that portion of stock maintenance costs relating to covered patient care services would be allowable. Further, the reasonableness of trademark related costs should be given special consideration in relation to the magnitude of total costs.

Moreover, because of the variable magnitude of these costs and the possibility of unreasonable costs, the Board instructs the Intermediary to make sure that the allowed "Stock Maintenance Costs" (Stockholders Servicing Costs) are reasonable and, by comparing the costs with other companies in the same or a related field, are costs which would be incurred by a prudent buyer.

Unanimous Decision

* * *

APPENDIX I

Health Care Financing Administration

Decision of the Administrator

In the Case of:

HUMANA INC. GROUP APPEAL
Provider

vs.

BLUE CROSS ASSOCIATION/VARIOUS
BLUE CROSS PLANS
Intermediary

Claim for:

Provider Cost Reimbursement
Determination of Reasonable Costs
for Cost Reporting Period(s) Ending
August 31, 1973

Review of:

PRRB Decision No. 79-D89
Dated: December 1, 1977

This case is before the Administrator, Health Care Financing Administration, for review on his own motion of the decision entered on December 1, 1977, by the Provider Reimbursement Review Board. The review is undertaken pursuant to Section 1878(f)(1) of the Social Security Act, as amended [42 USC 1395oo(f)]. . . .

* * *

ISSUES AS STATED BY THE BOARD

* * *

"3. Whether stock maintenance expenses incurred by the Providers and/or allocated to them by its Parent Corporation are allowable costs under the terms of the Medicare Law and Regulations?"

* * *

DISCUSSION AND EVALUATION

The entire record which was before the Provider Reimbursement Review Board, including the transcript of the oral hearing, all position papers, and exhibits, submitted by the parties has been examined. The Board's decision has been carefully reviewed and all comments received after the Board issued its decision have been closely noted by the Administrator.

* * *

Issue 3

This issue concerns whether the costs identified and classified in the record as the Parent Company's stock maintenance costs which were allocated to the Providers in this appeal may be allowable for Medicare reimbursement purposes. The Board held that stock maintenance costs are indirectly related to patient care. The Board found that Section 2134.9 and 2150.2B of the Provider Reimbursement Manual, HIM-15, exclude stock maintenance costs from allowable costs, but that these Sections are inconsistent with Section 1861(v)(1) of the Social Security Act, as amended [42 USCA 1395(x)] which permits reimbursement of indirect costs related to patient care. The Board also viewed stock maintenance costs as similar to the costs of borrowing funds which are allowable by the Medicare program. Finally, the Board disagreed with the Intermediary that stock maintenance costs are allowable through the return on equity capital because it found that the return was not established for this purpose.

The Parent Company and the Providers are related organizations under 20 CFR 405.427. 20 CFR 405.427(b)(1) defines "related to provider . . ." as "the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies." By virtue of ownership of 100 percent of the stock of the Providers, the Parent Company "has the power directly or indirectly, significantly to influence or direct the actions or policies . . ." of the Providers and accordingly, meets the definition of control under 20 CFR 405.427(b)(3).

Under 20 CFR 405.427(a), "costs applicable to services, facilities, and supplies . . ." furnished to a provider by an

organization to which it is related by control may be considered allowable costs of the providers, subject to several limitations. Therefore, where the Parent Company furnishes services, facilities, and supplies to its related Providers, the reasonable costs of such items may be allowable.

A review of the governing law shows that Section 1861 of the Social Security Act, as amended [42 USCA 1395x] lists and defines many specific items, such as surgical dressings, splints, braces, etc., which are to be considered reimbursable "services, facilities, or supplies" for Medicare purposes. There is, however, no mention of stock maintenance costs as being covered "services, facilities, or supplies." A review of the legislative history of the Act reveals no indication that the Congress considered stock maintenance costs as a service, facility, or supply.[1]

Under the Medicare Act, a 16-member body was created in 1965 for the purpose of providing advice in the formulation of Medicare regulations.[2] This group was named the Health Insurance Benefits Advisory Council. The Council in its discussion of the principles of reimbursement, upon which the Reimbursement Regulations are based, did not mention stock maintenance costs when discussing services, facilities, and supplies.[3]

This review of the Act and its legislative history, and of the Regulation and background, reveals no basis for any holding that stock maintenance costs are a service, facility, or supply. Since only the costs applicable to services, facilities, and supplies furnished to the Providers by a related organization, in this case the Parent Company, are includable in the allowable costs of the Providers under 20 CFR 405.427(a), it follows

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[1] S. REP. NO. 404, 89th Cong., 1st Sess. 36 (1965), at 27-28, 31, 33, 48, 185; H.R. REP. NO. 213, 89th Cong. 1st Sess. 32 (1965), at 24-25, 28-29, 41, 167.

[2] Social Security Act § 1867, 79 Stat. 286 (1965), *as amended* 42 U.S.C. § 1395 dd. (1970).

[3] Health Insurance Benefits Advisory Council: *Minutes*, Chronological Summary of 3d meeting at 35 (Dec. 17-19, 1965); Health Insurance Benefits Advisory Council: *Minutes*, Chronological Summary of 5th meeting at 29 (Jan. 28-30, 1966).

that stock maintenance costs may not be allowed under this Regulation.

Stock maintenance costs are costs of the Parent Company which are not subject to allocation to the Providers for Medicare reimbursement purposes. The Providers received no services, facilities, or supplies as a result of the Parent Company incurring stock maintenance costs to maintain its own corporate status and equity capital. The relationship between the Parent Company and the Providers does not bestow a right to shift costs applicable only to the Parent Company to the Providers with the resultant effect of obtaining Medicare reimbursement for such costs.

Even if the stock maintenance costs could be considered a service, facility, or supply, these costs cannot be considered reasonable costs related to patient care. Reasonable cost for program reimbursement purposes is defined in Section 1861(v)(1)(A) of the Social Security Act, as amended [42 USCA 1395x]. This Section requires that "reasonable cost . . . be the cost actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. . . ." Further, the "regulations shall (i) take into account both direct and indirect costs of providers of services. . . ." It is clear from this reading that the regulations were meant to further define reasonable costs by specifically stating the methods and items involved in the reasonable cost determination. However, the Act mandates that costs unnecessary to render patient care services are not reasonable costs.

A review of 20 CFR 405.451(a) shows that payments to providers "must be based on the reasonable cost of services covered under Title XVIII of the Act and related to the care of beneficiaries." Reasonable cost includes "necessary and proper costs incurred in rendering the services. . . ." Under 20 CFR 405.451(b)(1), reasonable cost "must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included." 20 CFR 405.451(b)(2) amplifies that necessary and proper costs are

only those costs which are "appropriate and helpful in developing and maintaining the operatino of patient care facilities and activities." Also, necessary and proper costs are those "common and accepted occurrences in the field of the provider's activity." 20 CFR 405.451(c)(3) requires, in pertinent part, that "where the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, . . . such amounts will not be allowable." Moreover, the cost of "items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services . . ." are not allowable.

To the extent that the Parent Company incurred patient care costs directly for the Providers in this appeal, such costs are included in the Providers' allowable costs under § 2150.2A of the Manual. Such costs incurred by the Parent Company are considered by the program to be home office costs. Where home office costs are not "otherwise allowable costs when incurred directly by the provider . . .," these costs may not "be allowable as home office costs to be allocated to providers." This Manual section is a proper interpretation of the Act and 20 CFR 405.451 in that a home office cost must be related to patient care services furnished by providers in order to be allowable under the program.

Concerning stock maintenance costs, there is no reference to these specific costs in either the Act or the Regulations. However, two sections in the Manual provide an interpretation of the regulations concerning whether stock maintenance costs are related to patient care. Section 2150.2B.1 of the Manual describes the home office costs which are not considered allowable. This Section refers to Section 2134.9 in disallowing stock maintenance costs. Section 2134.9 of the Manual explains that stock maintenance costs "are not related to patient care. . . ." Also, such costs are "incurred primarily for the benefit of stockholders or other investors. . . ."

The Providers' contention that Section 2134 of the Manual only applies to cost reporting periods after June 30, 1976, and not to the Providers' cost reporting period in dispute, is noted. The current Section 2134, titled "Organizations and Other

Corporate Costs," which was placed in the Manual by Revision No. 158 dated June 1976, does contain the effective date of June 30, 1976. However, § 2134.9 concerning stock maintenance costs was originally placed into the Manual in August 1973, by Revision No. 75. The transmittal sheet to Revision No. 75 explained that § 2134 "has been revised for purposes of clarification." Section 2134 was first published in the Manual in June 1969, by Revision No. 7. With reference to stock maintenance costs, § 2134.1 explained that "Costs connected with issuing or selling shares of stock, or other securities, such as commissions and professional fees, . . . are not includable in organization costs, but are capital expenditures."

Further review of the Manual shows that Section 2150, dealing with home office costs, was first placed in the Manual by Revision No. 68 dated January 1973. Under § 2150.2B in that Revision, "Costs relating to corporate stock maintenance . . ." were not considered allowable costs. This transmittal sheet to Revision No. 68 explained that § 2150 was added to the Manual to clarify "the treatment of home office costs for Medicare reimbursement purposes. . . ." Accordingly, from this examination of the applicable Manual Sections, it is clear that the provisions of § 2134.9 which are now reflected in the Manual apply to the Providers in this appeal.

Section 2150.2B.1 and § 2134.9 present a clear statement that stock maintenance costs are not allowable costs under the program. These costs are disallowed because they are not considered to be related to patient care. Rather, the costs are incurred for the benefit of the corporation's stockholders. Since these costs are "specifically not reimbursable under the program . . ." as not relating to patient care, 20 CFR 405.451(c)(3) requires that "such amounts will not be allowable." The Manual instructions are clearly interpretive of the Regulation in disallowing stock maintenance costs as not related to patient care.

A review of the evidence of record in this case reveals that the Providers and the Intermediaries disagree as to the proper classification of the legal costs and amortized costs relating to the Parent Company's name (trademark costs). The Providers classified these costs as stock maintenance costs, while the

Intermediaries classified the costs as advertising costs. The Administrator is of the opinion that the trademark costs relate to both classifications. However, in either classification, the costs must be related to patient care to be allowable. Under § 2136 of the Manual, the allowability of advertising costs "depends on whether they are reasonable, appropriate, and helpful in developing, maintaining, and furnishing covered services to Medicare beneficiaries. . . ." This Manual Section is an interpretation of 20 CFR 405.451 in requiring that costs be related to patient care to be allowable. Therefore, the classification of trademark costs is not important with respect to their allowability in this case. Accordingly, the discussion and evaluation of stock maintenance costs in the case at hand can apply equally to trademark costs.

Testimony of several witnesses at the hearing before the Board attests to the relationship of costs identified as stock maintenance costs in this case to equity capital. There was testimony that a publicly held corporation must incur stock maintenance costs, and that these costs provide a basis for maintaining equity of the corporation. However, the equity in publicly held corporations is not contested. Such costs are incurred by publicly held corporations to keep present investors and to attract new investors. The functions of these costs also serve to protect and inform the investors in the Parent Company's stock, and to assure the transfer of stock among investors.

Nevertheless, patient care services may be rendered without incurring stock maintenance costs. It is the construction of the organizational entity providing the services, not the patient care services, which gives rise to stock maintenance costs. It is recognized that some stock maintenance costs are necessary for a publicly held corporation to maintain its corporate status; however, these costs are not "related to the care of beneficiaries . . ." as required by 20 CFR 405.451(a).

Stock maintenance costs are not "appropriate and helpful in developing and maintaining the operation of patient care facilities and activities," or "common and accepted occurrences in the field of the provider's activity," as required by 20 CFR 405.451(b)(2) in order to be viewed as necessary costs related

to patient care. If these costs were related to patient care, the costs would be incurred by hospitals operated by nonprofit institutions and those providers which do not have shareholders. However, this is not the situation. Patient care services may be rendered by hospitals which are not publicly held corporations without incurring stock maintenance costs. Consequently, patient care services do not give rise to stock maintenance costs. Thus, stock maintenance costs are not necessary for patient care.

The Providers' comment that the disallowance of stock maintenance costs discriminates between investor-owned and nonprofit providers is noted. It is the Administrator's opinion that the disallowance of costs not related to patient care is not discriminatory. The fact that stock maintenance costs are unique to publicly held corporations does not alter the determination that the costs are not related to patient care. The costs are not disallowed solely because they are not incurred by all providers.

The Act and 20 CFR 405.451 impose a strict definition on reasonable cost. In order for a cost to be reimbursable under the program, it must, among other limitations, be related to patient care. No matter how necessary stock maintenance costs may be to the Parent Company in maintaining its corporate existence, these costs cannot be construed as relating to the patient care services of the Providers since patient care services do not generate such costs. Further, costs that are not necessary for the efficient delivery of needed health services are not reimbursable under Section 1861(v)(1)(A) of the Act [42 USC 1395x].

The program allows a return on equity capital invested and used in the provision of patient care by proprietary providers. The amount allowable is determined by applying to the providers' equity capital a percentage equal to one and one-half times the average rate of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each month in the providers' reporting periods.

The relationship between stock maintenance costs and the return on equity capital allowed under the program requires a

review of Section 1861(v)(1)(B) of the Act, as amended [42 USCA 1395x]. Here, a specific item relating to the owner's investment in facilities rendering extended care services is included in reasonable cost. This Section requires that the "regulations in the case of extended care services furnished by proprietary facilities shall include provisions for specific recognition of a reasonable return on equity capital . . . in lieu of other allowances to the extent that they reflect similar items." The following sentence states that the return on equity capital is "for determining the reasonable cost of [illegible] services furnished. . . ." The return on equity capital, therefore, is viewed as a part of reasonable cost, in lieu of other allowances to the extent they reflect similar items.

It is interesting to note that Section 1861(v)(1)(B) of the Act [42 USC 1395x], refers only to extended care services, not to hospital services. The Regulation, 20 CFR 405.429, however, permits a return on equity capital for hospital services as well. A review of the history of this Section of the Act is necessary. Section 1861(v)(1)(B) was enacted nearly a year after the enactment of the Medicare program, including Section 1861(v)(1)(A). In the Conference Committee's Report which accompanied H.R. 6958, subsequently codified as Section 1861(v)(1)(B), similar principles were expected to be applied to proprietary hospitals: "The conferees expect that the Secretary of Health, Education and Welfare will apply similar or comparable principles in determining reasonable costs for reimbursement of proprietary hospitals for services furnished by them." (H.R. REP. NO. 2317, 89th Cong., 2d Sess. (1966), p. 31, U.S. Code Cong. & Admin. News 1966, p. 3676, 3692, and 3693).

Congress intended that similar or comparable principles to those in Section 1861(v)(1)(B) of the Act be applied in the Regulations to proprietary hospitals. The Regulation permitting an allowance for return on equity capital for hospitals is 20 CFR 405.429. Subpart (a) is specific in permitting a return on equity capital used in rendering patient care services "as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers." The purpose of allowing a return on equity capital is stated in 20 CFR

405.429(b)(1) "to avoid withdrawal of capital and to attract additional capital needed for expansion." Thus, under this Regulation, the return on equity capital recognizes the investment for patient care and that an allowance for this investment is a necessary cost under the program.

Clearly, then, 20 CFR 405.429, like Section 1861(v)(1)(B) of the Act, names a specific item for inclusion in reasonable costs. In addition to reimbursing providers the actual costs of rendering extended care services under Section 1861(v)(1)(A), Congress also intended that a return on investment in patient care activities be paid proprietary hospitals. Section 1861(v)(1)(B) states that this return is "in lieu of other allowances to the extent that they reflect similar items." While the legislative history of Section 1861(v)(1)(B) contains no specific reference to this statement, it appears evident that Congress intended to allow the return on investment in patient care facilities rather than allowing specific items of cost relating to the investment.

Because 20 CFR 405.429, as it relates to hospitals, adopted "similar or comparable principles" to those contained in Section 1861(v)(1)(B), the basic principle that the allowance is "in lieu of other allowances to the extent that they reflect similar items" was extended to hospitals in the Regulation. The only allowance for investment in patient care which is permitted by this Regulation is the return on equity capital.

The stock maintenance costs in this case have the objective of maintaining equity capital for the Parent Company. 20 CFR 405.429 achieves this objective for the Providers by allowing a return on equity capital. To permit the Board's decision to stand and allow stock maintenance costs of the Parent Company would circumvent this Regulation. The Regulation clearly intends to allow only the return for the Providers. This would be true even in situations where providers directly incur stock maintenance costs. Surely, it would be a misinterpretation of the Regulation in this case to allow stock maintenance costs of the Parent Company plus a return on equity capital for the Providers.

The argument that stock maintenance costs should be allowable because they are similar to costs of borrowing funds

is noted. The Administrator agrees that the costs in both instances are incurred in obtaining funds. However, in this case, stock maintenance costs relate to the stockholders of the Parent Company, not to indebtedness for patient care. The stockholders constitute the corporation's owners. Clearly, the distinction between the ownership of the Parent Company and indebtedness relating to the Providers cannot be removed simply because the costs related to each have the objective of obtaining funds.

FINDINGS OF FACT

1. The amount of Medicare reimbursable costs in controversy for this group appeal exceeded $50,000, exclusive of interest and costs, for the cost reporting period ending August 31, 1973.

2. The 48 Providers in this group appeal are acute care hospitals and wholly-owned subsidiaries of the Parent Company, Humana Inc.

3. The Parent Company was incorporated in Delaware in 1964 to succeed a nursing home company, known as Extendicare, which began operations in 1961.

* * *

Issue 3

19. Medicare reimbursement for the stock maintenance costs incurred by the Parent Company, Humana Inc., during its fiscal year ending August 31, 1973, are in dispute.

20. The Parent Company allocated its stock maintenance costs to the 48 Providers in appeal on this issue.

21. The Providers did not receive any health care services, facilities, or supplies for the stock maintenance costs incurred by the Parent Company.

22. The Providers claimed the allocated stock maintenance costs for reimbursement under the Medicare program.

23. The stock maintenance costs were incurred by the Parent Company to maintain its equity and corporate status.

24. The Intermediaries disallowed Medicare reimbursement for the Parent Company's stock maintenance costs allocated to the Providers.

CONCLUSIONS OF LAW

* * *

Issue 3

13. The Parent Company and the Providers are organizations related by control within the meaning of 20 CFR 405.427(a) and (b)(3).

14. The Parent Company's stock maintenance costs allocated to the Providers did not constitute services, facilities, and supplies furnished by a related organization under 20 CFR 405.427(a) or Section 1861 of the Act [42 USCA 1395x].

15. Not representing services, facilities, and supplies furnished by a related organization, the Parent Company's stock maintenance costs allocated to the Providers are not includable in the allowable costs of the Providers under 20 CFR 405.427(a).

16. The Parent Company's stock maintenance costs allocated to the Providers are not necessary for the Providers' efficient delivery of services covered by Medicare under Section 1861(v)(1)(A) of the Social Security Act, as amended [42 USCA 1395x].

17. The Parent Company's stock maintenance costs allocated to the Providers do not represent reasonable costs of services covered by Medicare and related to the care of beneficiaries as required by 20 CFR 405.451(a).

18. Medicare funds may not be used to reimburse the Providers for the stock maintenance costs under 20 CFR 405.451(a).

19. The Parent Company's stock maintenance costs claimed by the Providers are not necessary and proper costs appropriate and helpful in patient care activities, neither are they common and accepted occurrences in the field of Providers' activities as required by 20 CFR 405.451(b)(2).

20. The claimed stock maintenance costs of the Parent Company are specifically excluded from program reimbursement and in excess of costs necessary for needed health services under 20 CFR 405.451(c)(3) as interpreted by § 2134.9 and § 2150.2B.1 of the Provider Reimbursement Manual (HIM-15).

21. The return on the Providers' equity capital invested and used for patient care is the only cost permitted for investment under 20 CFR 405.429(a).

22. Being costs related to the Parent Company's investment, the Parent Company's stock maintenance costs allocated to the Providers are not reasonable costs related to patient care under Section 1861(v)(1)(B) of the Social Security Act, as amended [42 USCA 1395x].

DECISION

* * *

Issue 3

The decision of the Provider Reimbursement Review Board on Issue No. 3 is reversed. The stock maintenance costs incurred by the Parent Company and allocated to the Providers are not allowable.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Date: January 31, 1978

/s/ ROBERT A. DERZON

Robert A. Derzon
Administrator
Health Care Financing
Administration

APPENDIX J

Provider Reimbursement Review Board

Hearing Decision

77-D89

Provider—Group Appeal of Humana Inc.,
Louisville, Kentucky, Provider Nos. Various
(See Attachment), Case No. 76-197G

v.

Intermediary—Blue Cross Association/Various Blue Cross Plan
(See Attachment)

Re: Cost Reporting Period Ending August 31, 1973

Date of Hearing—July 19, 1977 and July 20, 1977

* * *

ISSUES:

* * *

2.A Whether taxes assessed on a provider's net income derived from its participation in the Medicare program are allowable under the terms of the Medicare Law and Regulations?

2.B Whether tax liabilities are to be included in the calculation of equity capital?

* * *

STATEMENT OF FACTS—GENERAL:

The Providers hereinafter referred to as the Parent Company, which with its subsidiaries (48 hospitals) are engaged in the development, ownership, and operation of hospitals located primarily in the southern and southwestern United States. The Parent Company was incorporated under the laws of the State of Delaware in 1964 to succeed to a business that commenced

operation in 1961. The Intermediaries audited the Parent Company and its subsidiaries for the cost year ended August 31, 1973 and issued Notices of Program Reimbursement which were received between December 15, 1975 and February 28, 1977. Each Provider has submitted a Notice of Program Reimbursement for the cost year being appealed. Not every notice is accompanied by supporting documentation of specific adjustments. However, the Intermediary has stated that the disputed amounts for all Providers included in the group are correct.

* * *

STATEMENT OF FACTS:

Issue No. 2A and 2B—Income Taxes and Income Tax Liability and Equity Capital

The Parent Company and certain of the Providers included as a cost in their cost reports the amount of income taxes (for the most part Federal Income Taxes) totaling $4,225,000 for the 1973 cost year. The Intermediary disallowed this cost with a resulting reduction in Medicare reimbursement of approximately $547,000. The major portion of the amounts disallowed were the aggregate Federal Income Taxes included in Home Office Costs and allocated to the Providers. After disallowance of the tax portion of Home Office Costs, the allocations to Providers were appropriately adjusted. It is these adjustments that are being appealed by teh Parent Company on behalf of the Providers.

* * *

CONCLUSIONS AND FINDINGS:

The Provider Reimbursement Review Board, after considerations of the facts, parties' contentions, the evidence presented at the hearing and briefs submitted subsequent to the hearing concludes and finds that in the instant case there is substantial evidence and justification to affirm the Intermediary's adjustments.

Issue No. 2A—Income Taxes

The Board recognizes that the return on equity rate is a before-tax rate where income taxes are not an allowable cost. It further recognizes that there is nothing specific in either the Law or the Regulations which states that the return on equity rate is intended to be a before-tax rate or an after-tax rate. However, the allowance of a rate of return on the equity capital of proprietary providers has been part of the Medicare program since its inception over 10 years ago and has been uniformly interpreted as a before-tax rate during that period. In the absence of any evidence to the contrary, the Board believes the intention is proclaimed by the long history of uniform interpretation.

The Board recognizes the cogency of the Parent Company's argument that the allowable return even if it were considered an after-tax rate is not sufficient, by itself, to attract equity capital and that this is much more true if it is considered a before-tax rate of return. However, the Board believes, in the absence of any other indication, that it is likely that the Congress intended the allowance of a rate of return on equity to assist in the raising of capital without necessarily being sufficient by itself to permit attracting investors.

The Board cannot agree with the Intermediary's contention that Medicare as a cost reimbursement program has not generated taxable profits. The allowance Medicare makes for a return on equity, whether or not designated by the Law and Regulations as a "cost" as is the case, is clearly a taxable profit. On the other hand, the Parent Company is asking Medicare to reimburse it for a proportion of its total income tax cost based on the percentage of Medicare use of its facilities. The figures submitted by the Parent Company as to the relative profits on Medicare vs. non-Medicare patients strongly suggest that the result would substantially overcharge Medicare if the Board were to accept the Parent Company's basic contentions and method of calculation. In fact, it might be said that one indication that the return on equity rate was never intended to permit the allowance of income taxes as a cost is the fact that no formula has ever been suggested by the Medicare program for

the calculation of the Medicare share of income taxes. If the return on equity capital is to be calculated on an after-tax basis, it should be a decision of the Congress.

The Board notes the Parent Company's argument that the need to make a greater profit on non-Medicare patients to produce a company profit enabling it to continue to attract new equity capital represents a subsidization of Medicare costs by nonMedicare patients. The Board feels that the requirement of cost reimbursement under the Law and Regulations refers specifically to costs of directly rendering patient care and does not need to be extended to the return on equity capital which is a profit over and above actual costs as generally defined in the field.

The Board has previously ruled that the disallowance of income taxes as a cost does not affect the need to include a liability for accrued income taxes in balance sheets for purposes of determining the amount of equity capital subject to the rate of return calculation. The Board is still of the same opinion.

In conclusion, the Board finds that most of the Parent Company's arguments are based on either (1) the lack of specificity of the Law and Regulations rather than any documentation to support its views, or (2) economic logic based on the premise that the return on equity percentage is intended to attract investors by its own figure, which premise is unsupported. Accordingly, the Board has determined that the method in use since the inception of Medicare should prevail.

Issue No. 2B—Income Tax Liability and Equity Capital

The treatment of income tax liability in relation to equity capital was not specifically made an issue by the Provider. There would be no question about it if income taxes were an allowable cost. The Board believes that this is a derivative issue when income taxes are not an allowable cost. Therefore, the majority of the Board repeats its position previously taken that whether income taxes are or are not allowable as costs, nevertheless the tax liability must be included in the computation of equity capital for Medicare reimbursement purposes.

DECISION:

Issue No. 2A—Income Taxes

The Board finds that the Parent Company is not entitled to consider income taxes as an allowable cost in order to make the rate of return on equity capital an after-tax return. The Intermediary's adjustments on this issue are affirmed.

Issue No. 2B—Income Tax Liability and Equity Capital

The income tax liability must be included in the determination of equity capital.

Majority—Issue No. 2A—Income Taxes

Arthur P. Owens
Harold Hinderer
Stanley P. Wilcox

December 1, 1977

/s/ ARTHUR P. OWENS
Arthur P. Owens, Chairman

Majority—Issue No. 2B—Income Tax Liability and Equity Capital

Arthur P. Owens
William E. Arnstein
Philip D. Bonnet

December 1, 1977

/s/ ARTHUR P. OWENS
Arthur P. Owens, Chairman

MINORITY OPINION of William E. Arnstein and Philip D. Bonnet:

Issue No. 2A—Income Taxes

These members concur with the main thrust of the decision with respect to the unallowability of Federal Income Taxes. As stated in a previous minority opinion, 77-D61, these members

believe that a distinction should be made between State and Local Income Taxes including other State and Local Taxes based on income (for example, Franchise Taxes) and Federal Income Taxes. The latter are calculated on the same basis regardless of the location or form of organization with relatively equal effect on all proprietary providers. The former (State and Local Income Taxes) vary widely from nothing to substantial amounts depending upon the individual state and to some extent upon the form of organization. Neither the Law nor the Regulations require that State and Local Income Taxes be excluded from allowable costs. Only the Program Instructions (PRM (HIM-15)) clearly exclude them. The return on equity capital is explicitly defined in the Law as part of allowable costs for proprietary providers and is taxable income. Therefore, proprietary providers should be treated similarly without regard to the State where they are located. This requires that State and Local Income Tax (and Franchise Taxes when based on income) be considered an allowable cost.

/s/ WILLIAM E. ARNSTEIN
William E. Arnstein

/s/ PHILIP D. BONNET
Philip D. Bonnet

December 1, 1977

MINIORITY OPINION of Harold Hinderer and Stanley P. Wilcox:

Issue No. 2B—Income Tax Liability and Equity Capital

In previous Provider Reimbursement Review Board Decisions 76-D25, 76-D63, and 77-D61, these members agreed with the Provider's argument that liabilities for income taxes should not be deducted from assets in the computation of the return on equity. Accordingly, we find the same minority opinion as rendered in 76-D25, 76-D63, and 77-D61 to be appropriate in the instant case.

The incurring of any liability is accompanied by the simultaneous happening of one or a combination of the following events:

(1) an asset is acquired
(2) another liability is reduced
(3) capital (owner's equity) is reduced.

In this case, neither party contends that an asset was acquired. Nor does either party contend that another liability was reduced. Instead, both parties agree that an accounting reduction in capital was concomitant with the recording of the income tax liability.

A reduction of capital can be classified as: a return to shareholders of invested capital (capital dividends); a distribution of earnings (dividends); a reduction of revenue; or, an expense ('cost' in the Medicare program). Clearly, the incurring of a liability for income taxes is not related to the returning of invested capital; the distribution of earnings; or, the reducing of revenue. By elimination, the incurring of an income tax liability which gave rise to the cost *is* related to patient care.

Section 1202.1 of the Provider Reimbursement Manual (HIM-15) would seem to be quite clear where it states: "In effect, equity capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicare program), adjusted for those assets and liabilities which are not related to the provision of patient care."

Section 1217 on which the Board relies, at least in part, for its decision appears to be an attempt to avoid the requirements of the Administrative Procedure Act. The BHI has published a dictum with no rationale to support it. To give such a dictum credence is regrettable. The Board's attempt to apply the matching concept to assets and liabilities rather than to revenue and expense alone is a bold one indeed. The accounting literature is sparse in support of the Board's stance.

The program's liability for income taxes differs from other liabilities which give rise to expenses. Liabilities for income taxes of any kind should not be deducted from assets in the computation of return on equity unless the tax expense which

results from the incurring of these liabilities is allowed as a reimbursable cost.

/s/ HAROLD HINDERER
Harold Hinderer

/s/ STANLEY P. WILCOX
Stanley P. Wilcox

December 1, 1977

STATEMENT OF FACTS:

Issue No. 3—Stock Maintenance Costs

After audit of the Parent Company's home office, the Intermediary initially disallowed expenses of $190,305 generally referred to as "stock maintenance costs," which had been allocated to Providers in proportion to the expenses of each. The nature and identity of these disallowed expenses pertained to: legal and accounting services involved in SEC filings, stockholder relations such as annual meetings and reports, certain employee publications, stock transfer agent fees, and amortization of trademark costs. The Intermediary relied on 2134.9 (stockholder servicing costs) and § 2136.2 (advertising costs) of the Provider Reimbursement Manual (HIM-15) as a basis for its disallowances.

Subsequent to the hearing, by letter the Parent Company and the Intermediary agreed that the following costs are no longer at issue: (1) a communications identity study involving costs of $10,557; and (2) amortization of a portion of prepaid communications (Public Relations) to the extent of $41,614. The elimination of these two amounts leaves for this issue a balance of $138,134 disallowed for the 1973 cost year which affects Medicare reimbursement to the extent of approximately $39,500.

* * *

CONCLUSIONS AND FINDINGS:

The Provider Reimbursement Review Board, after consideration of the facts, parties' contentions, and evidence pre-

sented, concludes that in the instant case, there is substantial evidence and justification to reverse the Intermediary's adjustment. The Parent Company's stock maintenance costs are allowable costs and these costs are not covered by the return on equity capital.

The Board believes the Intermediary has properly followed the Manual Instructions (Sections 2134.9 and 2136.2) which apply to the particular determination but such Manual Instructions are inconsistent with regulations which support reimbursement of such costs. The Medicare Act requires reimbursement of all costs incurred by a provider if such costs are reasonably—although indirectly—related to the care of the program's beneficiaries. An examination of the Law 1861(v)(1) which defines "Reasonable Cost" shows the following:

> "(A) The reasonable cost . . . shall be the cost actually incurred . . . and shall be determined in accordance with regulations establishing the method . . ., and the items to be included . . .
>
> (B) Such regulations in the case of . . . services furnished by proprietary facilities shall include provisions for specific recognition of a reasonable return on equity capital, including necessary working capital in the facility . . . The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services . . . shall not exceed . . ."

Further, Regulation 405.429(a)(1) states: "A reasonable return on equity capital invested and used in the provision of patient care is allowable *as an element of reasonable cost* of covered services to beneficiaries by proprietary providers." (Emphasis supplied)

The position of BHI and the Intermediary seems to be that "Stock Maintenance Costs" are costs which relate only to investors and not to patient care and that such costs can only be reimbursed through the return on equity capital. The Board does not agree with that position.

The Board believes that "Stock Maintenance Costs" are indirectly related to patient care. It is not reasonable to claim

that all "Stock Maintenance Costs" are unrelated to patient care services. It is inconsistent to allow the costs of borrowing funds and not to allow the related and necessary stock maintenance costs. "Stock Maintenance Costs" have many things in common with the costs of acquisition of borrowed funds. The program allows the expenses on borrowed capital and the Board fails to see a distinction between expenses related to borrowed capital and stock maintenance. The cost of procuring equity funds does not differ in substance from the cost of obtaining any other type of capital. The Board believes that those specific costs related to trademark and trade name are marginal in relation to patient care.

Stock maintenance costs apply primarily to the Parent Company. Each Provider, all the stock of which is held by the Parent Company, has no significant stock maintenance costs of its own. However, the equity capital raised by the Parent Company is used to provide facilities and services for patient care. When that capital is made available to a Provider (subsidiary), usually through an intercompany loan, the capital is recognized by Medicare as part of the equity capital of the Provider but no interest on the loan is allowed because it is a loan between related parties However, when a Provider borrows directly from a bank or a similar unrelated party, then both the costs of borrowing and the interest would be allowable.

In this case, the equity capital of the Parent Company becomes directly involved in the provision of patient services to Medicare beneficiaries through intercompany loans. Therefore, the Board believes that the cost of acquiring equity capital in the capital money markets should be an allowable cost.

The Board does not agree with the Intermediary that "Stock Maintenance Costs" become allowable costs through the return on equity capital. The return on equity was not set up for this purpose. Such costs are indirectly related to patient care and, therefore, should be reimbursed on a cost basis. Furthermore, no evidence was presented by the Intermediary to establish that recognition had ever been given in the rate of return to reflect the inclusion of "Stock Maintenance Costs."

DECISION:

The disallowance by the Intermediary of "Stock Maintenance Costs" (Stockholder Servicing Costs) is reversed. These costs are related indirectly to patient care and are not covered by the rate of return on equity capital. To the extent that the Parent Company engages in activities other than covered patient care services, only that portion of stock maintenance costs relating to covered patient care services would be allowable. Further, the reasonableness of trademark related costs should be given special consideration in relatino to the magnitude of total costs.

Moreover, because of the variable magnitude of these costs and the possibility of unreasonable costs, the Board instructs the Intermediary to make sure that the allowed "Stock Maintenance Costs" (Stockholders Servicing Costs) are reasonable and, by comparing the costs with other companies in the same or a related field, are costs which would be incurred by a prudent buyer.

FOR THE BOARD:

December 1, 1977

/s/ ARTHUR P. OWENS
Arthur P. Owens, Chairman

* * *

Issue No. 2A—Income Taxes

The Board finds that the Parent Company is not entitled to consider income taxes as an allowable cost in order to make the rate of return on equity capital an after-tax return. The Intermediary's adjustments on this issue are affirmed.

Issue No. 2B—Income Tax Liability and Equity Capital

The income tax liability must be included in the determination of equity capital.

Majority—Issue No. 2A	Majority—Issue No. 2B
Arthur P. Owens	Arthur P. Owens
Harold Hinderer	William E. Arnstein
Stanley P. Wilcox	Philip D. Bonnet

Issue No. 3—Stock Maintenance Costs

The disallowance by the Intermediary of "Stock Maintenance Costs" (Stockholder Servicing Costs) is reversed. These costs are related indirectly to patient care and are not covered by the rate of return on equity capital. To the extent that the Parent Company engages in activities other than covered patient care services, only that portion of stock maintenance costs relating to covered patient care services would be allowable. Further, the reasonableness of trademark related costs should be given special consideration in relation to the magnitude of total costs.

Moreover, because of the variable magnitude of these costs and the possibility of unreasonable costs, the Board instructs the Intermediary to make sure that the allowed "Stock Maintenance Costs" (Stockholders Servicing Costs) are reasonable and, by comparing the costs with other companies in the same or a related field, are costs which would be incurred by a prudent buyer.

APPENDIX K

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

SEPTEMBER TERM, 1984

No. 82-1986
Civil Action No. 78-00175

HUMANA INC., *et al.*,
Appellants

v.

MARGARET M. HECKLER, SECRETARY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 82-1987
Civil Action No. 81-01311

HUMANA INC., *et al.*,
Appellants

v.

MARGARET M. HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 82-1989
Civil Action No. 75-00302

HUMANA OF SOUTH CAROLINA, INC.,
doing business as Coleman-Aimar Hospital, a corporation,
Appellant

v.

MARGARET M. HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 82-1994
Civil Action No. 81-00853

HUMANA INC., *et al.*,
Appellants

v.

MARGARET M. HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 82-1995
Civil Action No. 78-00584

HUMANA INC., *et al.*,
Appellants

v.

MARGARET M. HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

APPEALS FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

Before: WALD and SCALIA, Circuit Judges,
and BAZELON, Senior Circuit Judge

JUDGMENT

These causes came on to be heard on records on appeal from the United States District Court for the District of Columbia, and were argued by counsel. On consideration thereof, it is

ORDERED and ADJUDGED, by this Court, that the judgment of the District Court appealed from in these causes is hereby affirmed in part, vacated in part, and these cases are remanded to the District Court with instructions, all in accordance with the Opinion for the Court filed herein this date.

Per Curiam
For the Court

/s/ GEORGE A. FISHER
George A. Fisher, Clerk

Date: April 2, 1985
Opinion for the Court Per Curiam

APPENDIX L

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

SEPTEMBER TERM, 1984
No. 82-1986
CA No. 78-00175

HUMANA INC., *et al.*,
v.
MARGARET M. HECKLER, SECRETARY
OF HEALTH AND HUMAN SERVICES
And Consolidated Cases

BEFORE: Wald and Scalia, Circuit Judges; and Bazelon, Senior Circuit Judge

ORDER

Upon consideration of the petition for rehearing of Margaret M. Heckler, Secretary of the Department of Health and Human Services, it is

ORDERED, by the Court, that the petition is denied.

Per Curiam

FOR THE COURT
GEORGE A. FISHER, CLERK

Dated: June 18, 1985

BY: /s/ ROBERT A. BONNER
Robert A. Bonner
Chief Deputy Clerk

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

SEPTEMBER TERM, 1984

No. 82-1986
CA No. 78-00175

HUMANA INC., *et al.*,
v.
MARGARET M. HECKLER, SECRETARY
OF HEALTH AND HUMAN SERVICES
And Consolidated Cases

BEFORE: Robinson, Chief Judge; Wright, Tamm, Wald, Mikva, Edwards, Ginsburg, Bork, Scalia and Starr, Circuit Judges; and Bazelon, Senior Circuit Judge

ORDER

The suggestion for rehearing *en banc* of Margaret M. Heckler, Secretary, Department of Health and Human Services has been circulated to the full Court and no member has requested the taking of a vote thereon. Upon consideration of the foregoing, it is

ORDERED, by the Court *en banc*, that the suggestion is denied.

Per Curiam

FOR THE COURT
GEORGE A. FISHER, CLERK

Dated: June 18, 1985

BY: /s/ ROBERT A. BONNER
Robert A. Bonner
Chief Deputy Clerk

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

SEPTEMBER TERM, 1984

No. 82-1986
CA No. 78-00175

HUMANA INC., *et al.*,
v.
MARGARET M. HECKLER, SECRETARY
OF HEALTH AND HUMAN SERVICES
And Consolidated Cases

BEFORE: Robinson, Chief Judge; Wright, Tamm, Wald, Mikva, Edwards, Ginsburg, Bork, Scalia and Starr, Circuit Judges; and Bazelon, Senior Circuit Judge

ORDER

Appellants' suggestion for rehearing *en banc* has been circulated to the full Court and no member has requested the taking of a vote thereon. Upon consideration of the foregoing, it is

ORDERED, by the Court *en banc*, that the suggestion is denied.

Per Curiam

FOR THE COURT
GEORGE A. FISHER, CLERK

Dated: June 18, 1985

BY: /s/ ROBERT A. BONNER
Robert A. Bonner
Chief Deputy Clerk

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

SEPTEMBER TERM, 1984

No. 82-1986
CA No. 78-00175

HUMANA INC., *et al.*,
v.
MARGARET M. HECKLER, SECRETARY
OF HEALTH AND HUMAN SERVICES
And Consolidated Cases

BEFORE: Wald and Scalia, Circuit Judges; and
Bazelon, Senior Circuit Judge

ORDER

Upon consideration of appellants' petition for rehearing, it is

ORDERED, by the Court, that the petition is denied.

Per Curiam

FOR THE COURT
GEORGE A. FISHER, CLERK

Dated: June 18, 1985

By: /s/ ROBERT A. BONNER
Robert A. Bonner
Chief Deputy Clerk

Supreme Court, U.S.
FILED
DEC 13 1985
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-431 (3)

In the Supreme Court of the United States

OCTOBER TERM, 1985

HUMANA INC., ET AL., PETITIONERS

v.

MARGARET M. HECKLER,
SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

CAROLYN B. KUHL
Acting Solicitor General

RICHARD K. WILLARD
Assistant Attorney General

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QUESTION PRESENTED

The Medicare Act, 42 U.S.C. 1395x(v)(I)(B), provides that proprietary providers of extended care services (*i.e.*, for-profit nursing homes) that participate in the Medicare program are entitled to be paid "a reasonable return on equity capital" at a rate that does not exceed a prescribed rate of return. The regulations of the Secretary of Health and Human Services extend this prescribed rate of return on equity capital to hospitals as well as nursing homes. 42 C.F.R. 405.429(a). The question presented is whether this method of compensating hospitals violates the general reimbursement provision of the Medicare Act, 42 U.S.C. 1395x(v)(1)(A), which states that providers are entitled to receive the "reasonable" costs, both direct and indirect, of providing necessary services to Medicare beneficiaries.

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In the Supreme Court of the United States

OCTOBER TERM, 1985

No. 85-431

HUMANA INC., ET AL., PETITIONERS

v.

MARGARET M. HECKLER,
SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1A-22A) is reported at 758 F.2d 696. The opinion of the district court (Pet. App. 25A-36A) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on April 2, 1985 (Pet. App. 94A), and a petition for rehearing was denied on June 18, 1985 (Pet. App. 98A). The petition for a writ of certiorari was filed on September 14, 1985. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. The portion of the Medicare program involved in this case, Part A, provides insurance for hospital and related post-hospital services. 42 U.S.C. 1395c, 1395d. Qualified

"providers of services" are reimbursed directly by the federal government for the costs of providing hospital and extended care to the Medicare Act's beneficiaries. Until October 1983, and as applicable to all claims for reimbursement involved in this case, the statute provided that providers treating Medicare beneficiaries were to be reimbursed under a retrospective, cost-based system. This system compensated the providers for the actual, reasonable costs incurred in providing Medicare services. 42 U.S.C. 1395f(b), 1395x(v)(1)(A). Congress did not specify a fixed formula for reimbursement, but rather authorized the Secretary of Health and Human Services to determine the method to be used in calculating such costs.

Statutory reimbursement for return on equity capital stands on a different footing. As originally enacted, the Medicare statute contained no provision concerning return on equity.[1] In 1966, Congress amended the Act to allow a return on equity capital for extended care services performed by proprietary providers (*i.e.*, for-profit nursing homes). Pub. L. No. 89-713, 80 Stat. 1107 *et seq*. Under this provision, the Secretary was directed to promulgate regulations to pay those providers a "reasonable return on equity capital * * * invested in the facility and used in the furnishing of * * * services" (42 U.S.C. 1395x(v)(1)(B)). The 1966 amendment provided that the rate of return was not to "exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund."

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[1]A regulation promulgated in 1966 authorized the recovery of an allowance amounting to 2% of otherwise allowable costs as reimbursement for items not specifically recognized, including return on equity. 20 C.F.R. 405.428 (1968). That regulation was rescinded in 1969. 34 Fed. Reg. 9927 (1969). See *Baylor University Medical Center* v. *Heckler*, 758 F.2d 1052 (5th Cir. 1985).

Ibid. As the legislative history indicates, Congress expected the Secretary to extend this allowance for return on equity not only to extended care facilities, but also to other proprietary hospitals. H.R. Conf. Rep. 2317, 89th Cong., 2d Sess. 3 (1966). In accordance with this congressional understanding, the Secretary promulgated regulations to allow all proprietary providers a reasonable return on equity capital. 20 C.F.R. 405.428 (1968) (31 Fed. Reg. 14816 (Nov. 22, 1966)).

In the 1983 amendments to the Social Security Act, Congress adopted a prospective payment system whereby providers are reimbursed not for actual costs, but instead at fixed pre-determined rates established for each category of patient services. Under this new system, capital costs, including return on equity, continue to be reimbursed as in the past, except that the 1983 amendments reduced the allowable rate for return on equity to providers for inpatient hospital services. 42 U.S.C. (Supp. I) 1395ww(g)(2).[2]

2. Petitioners, Humana Inc. and 64 of its subsidiary hospitals, brought this action challenging the denial by the Secretary of Health and Human Services of reimbursement for certain items claimed by petitioners as costs of their participation in the Medicare program. They raised numerous substantive and procedural challenges to the Secretary's denial of reimbursement for (1) stock maintenance costs, (2) income taxes and (3) stock acquisition costs. Petitioners also challenged the rate allowed by the Secretary for return on equity capital.

After the district court affirmed the Secretary's decisions on all issues raised by petitioners, the court of appeals affirmed in part and reversed in part. The court affirmed the

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[2]The allowance for return on equity for inpatient hospital services was reduced from one and one-half to one times the rate of interest paid by the Treasury on the assets of the Hospital Insurance Trust Fund. H.R. Conf. Rep. 98-47, 98th Cong., 1st Sess. 190 (1983).

disallowance of reimbursement for income taxes and the inclusion of income taxes in the calculation of return on equity capital as well as stock maintenance costs. The court, however, reversed the district court's holding "disallowing reimbursement for stock acquisition costs when an acquired corporation is liquidated or merged into the acquiring corporation" (Pet. App. 3A).[3]

As to the return on equity—the only issue raised in this Court—the court of appeals rejected petitioners' contention that "a proprietary hospital's return must be paid under 42 U.S.C. § 1395x(v)(1)(A) (1976), the 'reasonable costs' provision, rather than under 42 U.S.C. § 1395x(v)(1)(B) (1976), the subsection dealing with extended care facilities" (Pet. App. 13A). The court stated that its prior decision in *American Medical International, Inc.* v. *Secretary of Health, Education and Welfare (AMI)*, 677 F.2d 118 (D.C. Cir. 1981), aff'g 466 F. Supp. 605 (D.D.C. 1979), "precludes a finding that return on equity is payable under § 1395x(v)(1)(A), and since § 1395x(v)(1)(B) authorizes the Secretary to set a single, universal rate of return, we hold that Humana is not entitled to an individual determination of a 'reasonable' return on equity" (Pet. App. 14A).

ARGUMENT

The decision of the court of appeals is correct and does not conflict with the decisions of this Court or of any other court of appeals. Further review by this Court is not warranted.

1. The issue in this case is not whether petitioners will be reimbursed for their return on equity capital, but how much they will be reimbursed. It is our submission that the Secretary's regulations provide a reasonable basis for payment

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[3]The government has not filed a petition for a writ of certiorari to challenge this determination.

that is consistent with Congress's intent. In contrast, petitioners contend (Pet. 16; Pet. App. 12A-13A) that the rate of return on equity capital paid by the Secretary "consistently fails to meet the true cost of attracting capital" and that rather than receiving a fixed allowance for return on equity capital, the cost of attracting private investment capital should be recognized as " 'costs' for which the corporation must be reimbursed" (Pet. 11). Thus, although petitioners do not expressly so state, they apparently contend, as they did below, that the amount of each hospital's allowance for return on equity capital must be evaluated on a "hospital-by-hospital basis" (Pet. App. 13A). Petitioners' contentions have no merit and ignore the basic structure and legislative history of the Medicare Act.

As the statutory background demonstrates (see pages 1-3, *supra*), from the inception of Congress's decision to recognize return on equity as an item of Medicare reimbursement, Congress has declined to treat it as a cost of providing necessary care to Medicare patients subject to reimbursement based on the expenses actually incurred (42 U.S.C. 1395x(v)(1)(A)). Rather, Congress established a separate statutory allowance, which "has its own independent basis in the Medicare Act." *Sun Towers, Inc.* v. *Heckler,* 725 F.2d 315, 335 (5th Cir. 1984), cert. denied, No. 83-1867 (Oct. 1, 1984).

2. In the face of this purposeful difference in treatment, petitioners contend (Pet. 13) that the legislative history of the Medicare Act supports their assertion that Congress intended to follow the "universal practice" of compensating private business, as an item of cost, for the reasonable return of investment capital they utilize for the convenience of the public. However, petitioners fail to mention that all courts of appeals that "have carefully examined the legislative history of the return on equity capital provision * * * have demonstrated persuasively that a return on equity is

not a 'reasonable cost' as contemplated by the Medicare Act." *Sun Towers* v. *Heckler*, 725 F.2d at 335; see *AMI, supra; St. Francis Hospital Center* v. *Heckler*, 714 F.2d 872, 874-875 (7th Cir. 1983), cert. denied, 465 U.S. 1022 (1984); *Hospital Authority* v. *Heckler*, 707 F.2d 456 (11th Cir. 1983).

Petitioners do not attempt to distinguish these decisions. Instead, petitioners recite a highly truncated version of the legislative history (Pet. 13-15). But the materials they cite (largely excerpts from the Senate Finance Committee Staff Report and Senate Finance Committee Hearings on the initial proposed regulations for Medicare reimbursement) indicate, at the very most, that Congress believed some allowance for return on equity was appropriate. Those excerpts do not show that Congress intended that return on equity—which is a "profit, not a cost" (*Sun Towers* v. *Heckler*, 725 F.2d at 335)—be reimbursed on the same basis as other costs of providing care to Medicare patients.[4]

Moreover, petitioners are simply wrong in asserting that the legislative history shows that Congress intended that the 1966 amendment to the Medicare Act, which established a rate of return on equity capital for extended care facilities, should not apply to proprietary hospitals. When Congress enacted this amendment, it expressly stated its expectation that "the Secretary * * * will apply similar or comparable principles in determining reasonable costs for reimbursement of proprietary hospitals for services furnished by

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[4]In fact, the courts have concluded that "the exchanges between senators and administrators at the Hearing [on the proposed regulations] 'make it quite unequivocal that the Senate Committee members believed that a return on equity capital was not, and should not, be provided [by the Medicare Act].' " *Hospital Authority* v. *Heckler*, 707 F.2d at 458, quoting district court opinion, 522 F. Supp. at 572. See also *St. Francis Hospital Center* v. *Heckler*, 714 F.2d at 880-881, adopting district court opinion (544 F. Supp. 1167, 1181 (S.D. Ind. 1982)).

them." H.R. Conf. Rep. 2317, *supra,* at 3.[5] Of course, this is exactly what the Secretary did. 31 Fed. Reg. 14816 (1966). The Secretary has continued to treat return on equity as an independent allowance (42 C.F.R. 405.429 (1984)), not as a cost of operation, and Congress, which has amended the statute several times and left the allowance intact, has in substance ratified this practice. Indeed, as recently as 1983, when Congress revamped the Medicare reimbursement scheme by replacing the concept of reimbursement based on actual costs with a Prospective Payment System, it again left unchanged the separate treatment for return on equity. 42 U.S.C. (Supp. I) 1395ww(g)(2).

Thus, the court of appeals correctly concluded (Pet. App. 14A (citation omitted)) that return on equity is an "exception to the basic Medicare principle that reimbursement be limited to those costs actually incurred in providing patient care services." Since this interpretation is consistent with the decisions of all other courts of appeals that have addressed this issue, review by this Court is plainly unwarranted.[6]

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[5]In commenting on a Senate proposal that led to this amendment, Senator Long, Chairman of the Senate Finance Committee, viewed the provision for a return on equity as an allowance for profit and as an exception to the Medicare Act's specific reimbursement for reasonable costs. He stated (112 Cong. Rec. 27608 (1966)):

> What we sought was to guarantee to the individual who invested his funds in a facility organized for profit that he would receive a fair return on the money he had put into the operation. As the proposed medicare regulations stood he would have been only reimbursed for the actual costs of providing services with no specific return given on his investment.

[6]The court of appeals also was correct in rejecting petitioners' reliance on cases that held government-prescribed rates to be confiscatory and therefore violative of the Fifth Amendment prohibition on the taking of property without just compensation (Pet. App. 10A-11A). If a health care provider considers the rate of allowance for return on equity to be insufficient, the simple answer is that it does not have to participate in

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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the Medicare program, for participation is entirely voluntary. *St. Francis Hospital Center* v. *Heckler*, 714 F.2d at 875 ("[p]roviders who opt not to participate are free to serve persons not covered by Medicare and those potential Medicare recipients who are willing to forego Medicare benefits for the services provided"). Such a provider may then charge whatever rates its business judgment advises, a situation altogether unlike the cases upon which petitioners rely (Pet. 11-12). Those cases involved ratemaking in the utility industry where, as the court of appeals noted (Pet. App. 11A), "utilities are forced to operate within a tightly regulated scheme if they are to operate at all." In any event, this Court denied certiorari on virtually the same issue in *St. Francis Hospital Center*, and the same result should obtain here.

*The Solicitor General is disqualified in this case.

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HUMANA INC. *et al.*,
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OTIS M. BOWEN, M.D.,
SECRETARY OF HEALTH AND HUMAN SERVICES,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

REPLY BRIEF FOR PETITIONERS IN SUPPORT OF PETITION FOR CERTIORARI

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* A list of all parties and subsidiary corporations of Humana Inc. is set forth at page (ii) of the Petition for Writ of Certiorari.

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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REPLY MEMORANDUM FOR PETITIONERS

In his brief in opposition to Humana's Petition for Certiorari, the Secretary misinterprets Humana's claim that the decision of the court of appeals conflicts with previous decisions of the Court. Further, the Secretary

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* Otis M. Bowen, M.D. has been substituted as respondent for Margaret M. Heckler as the successor Secretary of Health and Human Services. *See* Sup. Ct. Rule 40.3.

erroneously introduces two sets of cases to suggest that the decision below need not be reviewed.

1. The Secretary suggests that, because Humana's sale of hospital services to Medicare patients is voluntary, the Fifth Amendment's guarantee of just compensation is inapplicable. Respondent's Brief at 7, n.6, *citing St. Francis Hospital Center v. Heckler,* 714 F.2d 872 (7th Cir. 1983), *cert. denied,* 465 U.S. 1022 (1984). Unlike the *St. Francis* hospitals, however, Humana acknowledges that no constitutional right is in question.

Instead, Humana contends that, consistent with the Court's interpretation of the Natural Gas Act in *FPC v. Natural Gas Co.,* 315 U.S. 575 (1942), the "reasonable cost" standard in the Medicare Act must be interpreted to be co-extensive with just compensation principles. Therefore, the statute itself dictates that these costs be reimbursed. This principle was clearly established in *FPC v. Natural Gas Co.,* but was not followed by the court below.

2. The Secretary has introduced a series of appellate decisions in which charitable hospitals sought the same return on equity capital paid to investor-owned facilities. *E.g.,* Respondent's Brief at 5-6, *citing St. Francis Hospital Center v. Heckler, supra; Hospital Authority v. Heckler,* 707 F.2d 456 (11th Cir. 1983). The courts in those cases properly concluded that Congress intended to depart from historic practices in developing reimbursement principles for *nonproprietary* hospitals. *E.g., St. Francis v. Heckler, supra,* 714 F.2d at 872. Those decisions, however, are not relevant in assessing whether *investor-owned* hospitals are entitled to a return on equity capital as a "cost" of care under subsection (A) of 42 U.S.C. § 1395x(v)(1). The Seventh Circuit itself limited the scope of its decision:

> . . . Congress did not intend a return on equity capital for nonproprietary providers to be

> reimbursable as a "reasonable cost" under 42 U.S.C. § 1395x(v)(1)(A). Any ambiguity we find goes to the issue of whether proprietary hospitals are entitled to such a return under either § 1395x(v)(1)(A) or (B), *an issue we need not decide at this point.* 714 F.2d at 875 (emphasis added).

3. The other group of decisions relied on by the Secretary includes cases in which proprietary facilities have sought reimbursement for costs attributable to their investor-owned status. In some of those cases the courts indiscriminately relied on decisions such as *St. Francis* involving charitable institutions, with absolutely no evaluation of whether those principles should be extended to proprietary facilities. *E.g., Sun Towers, Inc. v. Heckler,* 725 F.2d 314, 335 (5th Cir. 1984), *cert. denied,* No. 83-1867 (Oct. 1, 1984), *citing St. Francis v. Heckler, supra.*

In the other cases, proprietary hospitals have argued that the 1966 amendment to the Medicare Act, which established the formula-prescribed guarantee of return on equity capital for investor-owned nursing homes, mandates reimbursement of all proprietary costs incurred by investor-owned hospitals. *E.g., American Medical International, Inc. v. Secretary of Health, Education and Welfare,* 466 F. Supp. 605 (D.D.C. 1979), *aff'd,* 677 F.2d 118 (D.C. Cir. 1981). Those courts quite properly concluded that the nursing home amendment regarding a return on equity capital could not be used as a "bootstrap" for other claims of investor-owned hospitals. *E.g.,* 466 F. Supp. at 613. Those decisions cannot serve, however, as the basis for rejecting Humana's claim that these expenses constitute "costs" under the 1965 Act as originally written.

CONCLUSION

The legislative history of the Medicare Act relied upon by Humana indicates that Congress itself intended to continue the historic practice of recognizing the costs of private capital of proprietary hospitals as compensable costs of services. Therefore, before this drastic departure from historic practice is implemented, Humana respectfully requests that the Court review this issue.

Respectfully submitted,

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